The MODERN HOSPITAL

Vol. XXV November 1925 No. 5

Published monthly at 22-24 E. Ontario Street, Chicago, Ill., by The Modern Hospital Publishing Co., Inc.
Entered as second-class matter October 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879.
Subscription—United States, $3.00; Canada, $3.50; Foreign, $4.00.

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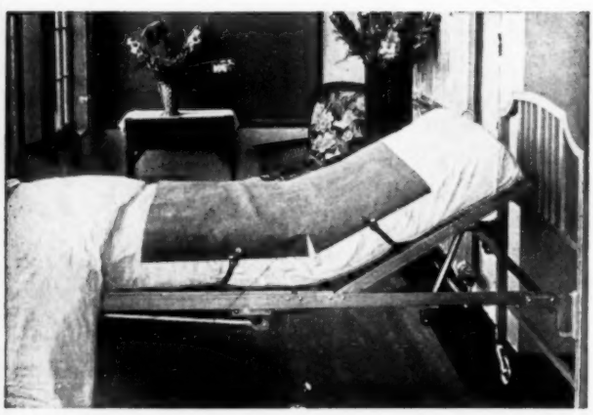

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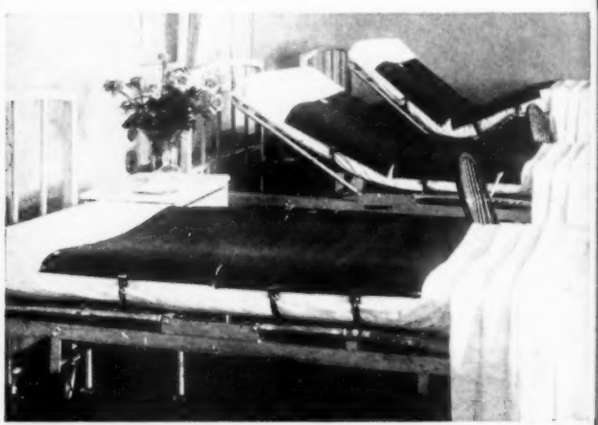

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXV *November 1925* No. 5

ACCOMPLISHMENTS AND OBJECTIVES OF A. H. A. OUTLINED BY PRESIDENT GILMORE*

By E. S. Gilmore, Superintendent,
Wesley Memorial Hospital, Chicago

ABOUT this time of the year a little over a quarter of a century ago a few hospital men got together in the city of Cleveland and formed an organization for the advancement of hospital interests under the name of "Hospital Superintendents' Association."

Out of that meeting has grown the American Hospital Association. Originally limited to hospital superintendents, today the association includes as members trustees and executive heads of every part of the hospital. For twenty years the association was little more than an annual convention. The president made all arrangements for the meeting, including the program.

If some are inclined to criticize the accomplishments let them remember that the association as a continuously functioning body is but eight years old. Today its institutional membership approximates one thousand and its active membership twice that number, while its influence reaches over eight thousand hospitals in the United States and Canada. It has a paid force of ten persons, constantly employed, while over one hundred members are engaged in committee and section work.

During the last year our membership and our organization sustained a great loss in the death of its executive secretary, Dr. Andrew R. Warner, who entered into a well-earned rest November 17, 1924. Doctor Warner gave unstintingly of his time, thought, and energy, and much that is good in the association is the product of his brain.

His successor, as well as predecessor, is Dr. William H. Walsh. Doctor Walsh gave up his duties as executive secretary to enter the World War, where he acquitted himself with distinction. It is fitting now that he should return to the work he loves and I am certain the future will endorse the wisdom of the trustees in calling him again to leadership.

The association is distinguishing itself in seeking to honor one of its older members, Dr. Henry M. Hurd. Doctor Hurd was our president in 1912 and was one of the first who engaged in active work. His activities at all times have been strenuous and his counsel wise. In recognition of his service and his rare personal qualities the trustees have voted to make Doctor Hurd an active life member of the American Hospital Association. The thought of the trustees in ex-

Goals to Achieve

THIS Association should aim to establish, develop, assist, coordinate, correlate, and guide hospitals toward the highest aims for which individually they were created. It is no mean task. It is one worthy the ambition of any group of men and women. When we extend medical or surgical assistance to the sick, we are relieving sorrow and helping individuals, families and communities. We are adding to the wealth of the community by changing non-producers to producers.

*Presidential address delivered before the twenty-seventh conference of the American Hospital Association at Louisville, Ky., October 19, 1925.

tending active membership to Doctor Hurd was to give him all the rights and privileges pertaining to that grade of membership and perfect freedom in exercising them. You will be asked to confirm this action of the trustees, which bestows the honor most worthily.

The American Hospital Association represents vast interests. Thousands of lives are constantly in its hands and the value of its property is estimated in billions of dollars. It might be well here to pause for reflection on the tremendous importance of the work which we, as hospital executives, are doing. We are spending over a million dollars a day for new buildings and equipment alone. We spend each year a billion dollars in the care of the twelve million people who come to us for aid. In addition to those in our immediate charge there are almost as many who come to our dispensaries and are represented by our social service departments and clinics. Few organizations have opportunity for contacts so close and so numerous. For in addition to the twenty million sick and injured whom we serve annually in various ways we reach at least sixty million friends and relatives who visit them. That means we have contact with eighty million people each year.

The Hospital as an Educational Center

Furthermore, the hospitals are educational centers, for we are conducting an elaborate school with branches all over the country. In this school more young women are studying nursing than are enrolled in all our universities and colleges. That these various influences are not futile is evident from our accomplishments. In support it is only necessary to mention that largely through the aid of hospitals the average length of life has been increased twenty-one years during the generation just past, and it may be freely predicted that another twenty-one years will be added in the next half century. In that event it will be disgraceful, if not criminal, for anyone to die under seventy-five years of age. I am mentioning these facts, which are familiar to all of you, merely to bring to your minds the magnitude and importance of the service in which we are engaged.

In business the day of millions is passing and the day of billions is upon us. As I said before, it costs to support the hospitals of the United States and Canada one billion dollars each year. Have you ever tried to comprehend the vastness of a billion? There have been less than a billion minutes since the crucifixion of Christ. If a billion soldiers were placed four abreast and spaced according to army regulations they would make a column reaching six times around the world at the equator; marching at the regular army pace they would require five years to pass a given point. The American Hospital Association annually sends a billion soldier dollars into the war against sickness.

The influence of our organization has spread widely and other countries are interested. New Zealand is now organizing its hospitals along our lines. Germany is showing interest in our methods and has promised to send a delegate to our convention next year.

Personnel Bureau Established

During the past year a personnel bureau has been established so that now we can give assistance both to those who are seeking hospital positions and to hospitals which are seeking employees. It is hoped that this department may become self-supporting. It will surely grow with the years and be of constantly increasing worth.

The association has been hampered hitherto for lack of office room. The trustees, realizing this, for some time have been trying to find a home. In furtherance of this idea they have made arrangements, which will be laid before you at this convention for such consideration and action as you may determine.

So large a union for a common purpose must vastly benefit the constituency. For instance, the association now has a committee which will report at this convention and the report will outline methods for the further education of hospital superintendents and others now in executive hospital work. Moreover, and this is far-reaching, it will undertake to arrange courses in universities for undergraduate study, leading to a degree in hospital administration. This will eventually place hospital superintendency among the professions and must ultimately provide a higher type of men and women for administrative positions. Marquette University, Milwaukee, already has started such a course and it is my hope that other universities will follow in the wake of this enterprising institution.

I am aware that in the addresses of my predecessors many suggestions have been made for advancement in our field of endeavor and that generally these suggestions have been marked by nonobservance. This may be due to an excess of optimism on the part of the association's titular heads or it may arise from mental myopia on the part of our trustees. In either event I am minded to advocate some changes, regardless of the oblivion to which my suggestions may be consigned.

I should like to see the influence of the association extended toward the more general provision of convalescent homes. They would provide

pleasanter and cheaper accommodations for patients recovering from illness and at the same time release hospital beds for acute cases. More hospitals for orthopedic correction are suggested, as well as more generous provisions for children. Additional homes for incurables are recommended and a less disheartening name by which to designate them.

I wish to extend a hearty welcome to the hospitals now in course of establishment by the Shriners and to endorse the facilities which the Rotarians are providing for the care of crippled children. Eleven hospitals of the former group are now institutional members of this association. Both these organizations are doing notable work. I rejoice that people who wish to help the world's unfortunates are turning so frequently to the hospital as the agency for accomplishing their desire.

Field Secretaries Needed

As soon as finances will permit I am sure the trustees will employ field secretaries so that every member of the association may be visited at least once each year, with a resultant interchange of views that will be helpful to the membership both individually and collectively. Work now done by committees, which must of necessity receive limited time and thought, could be done better by hospital experts in the employ of the association. In this connection I wish to assert my belief that many commercial firms would be willing to provide necessary funds for the investigation of hospital problems connected with the type of business represented by the firm. I believe, too, that the large foundations could be induced to finance hospital research work.

The association is participating in an investigation looking to the grading of nurse education. This is a department in which the hospital is almost as vitally interested as is the nurse. Upon its solution depends the future of the nursing profession.

I am hoping, too, that the time is not far away when our trustees will set up certain standards that every hospital that is a member of the association will find pleasure and profit in accepting. At present the idea is that we should help every hospital to become better, no matter how weak it may be. That is good, but may it not be that the greatest good may come through requiring all hospitals to meet a minimum of efficiency and urging those able to surpass the minimum to do so, thus clearing the way for the establishment of a higher minimum later. Standardization in a measure has been effected by the American College of Surgeons and its work is being well done. However, it is principally along medical lines.

When our standards are adopted they should demand not only those now required by the American College of Surgeons but, in addition, they should insist that the hospitals must meet certain grades of sanitation, hygiene, estheticism, morale, nurse and intern education and sympathetic care of the patient. A hospital that fails to comprehend that its chief duty is to its patients or, comprehending, fails to do its utmost for its patients' welfare and comfort is unworthy of membership in our association.

I should like to see our association widen its boundaries. We could be of great benefit to the hospitals of Central and South America and we owe it to the world's advancement that we extend that benefit. We should not feel, however, that the help will be one-sided, for there is much we can learn from our neighbors in the south. Perhaps the most beautiful hospital in the world, certainly the most beautiful I have ever seen, is in South America. I should like to see Central America represented at our conventions by properly accredited delegates so that reciprocal advantages may be extended from pole to pole.

The Convention as an Open Forum

These conventions more and more should become an open forum where every member feels free to give expression to opinions on hospital procedure. The association need not, in fact should not, except after careful consideration, formally endorse such opinions, but it should afford opportunity for discussion, the result of which cannot but be beneficial.

The association might well have a legislative secretary, to initiate favorable legislation and to combat that which is unfavorable. I believe our legislatures, both state and federal, would be willing to enact laws favorable to hospitals if convinced that such laws were proper. An instance of what Congress might do is to allow larger exemption from income tax of gifts to religious, charitable and educational institutions, and our state law-making bodies might well give hospitals the protection against "dead-beats" that is enjoyed by hotels.

In order that we may comprehend better the scope of the association's activities, let us consider for a moment what it is expected a hospital should accomplish. I quote from a paper read at another convention: "A hospital is an institution that provides facilities, including personnel, for extending medical and surgical assistance to the sick, for aiding and educating physicians, nurses, community organizations and the public, and for investigating the cause and cure of disease and the methods of its prevention."

The Rizzoli Orthopedic Institute at Bologna, Italy, overlooking the city.

DEVELOPING ORTHOPEDICS IN ITALY

By Ugo Barberi, Librarian,
L'Istituto Ortopedico Rizzoli, Bologna, Italy

THE Rizzoli Orthopedic Institute, Bologna, Italy, whose widespread fame is based primarily on the well merited reputation of its great founder, on the eminent men who in the past have directed its destinies and on the wonderful cures that have been wrought there, has now reached the climax of its influence through the talents of the famous orthopedist, Professor Vittorio Putti, who is already well known in America.

In 1880 the eminent Bolognese surgeon, Francesco Rizzoli, acquired from the province of Bologna the ancient convent of the Olivetan monks at St. Michael in Bosco, planning to use it for the foundation of an orthopedic institute, for the establishment of which he provided in his will by the allocation of the sum of 1,754,894 liras, accumulated in the practice of his profession. The dedication of the institute took place in 1896, in the presence of Humbert I, King of Italy, Marguerite of Savoy, and the Prince of Naples, our present sovereign.

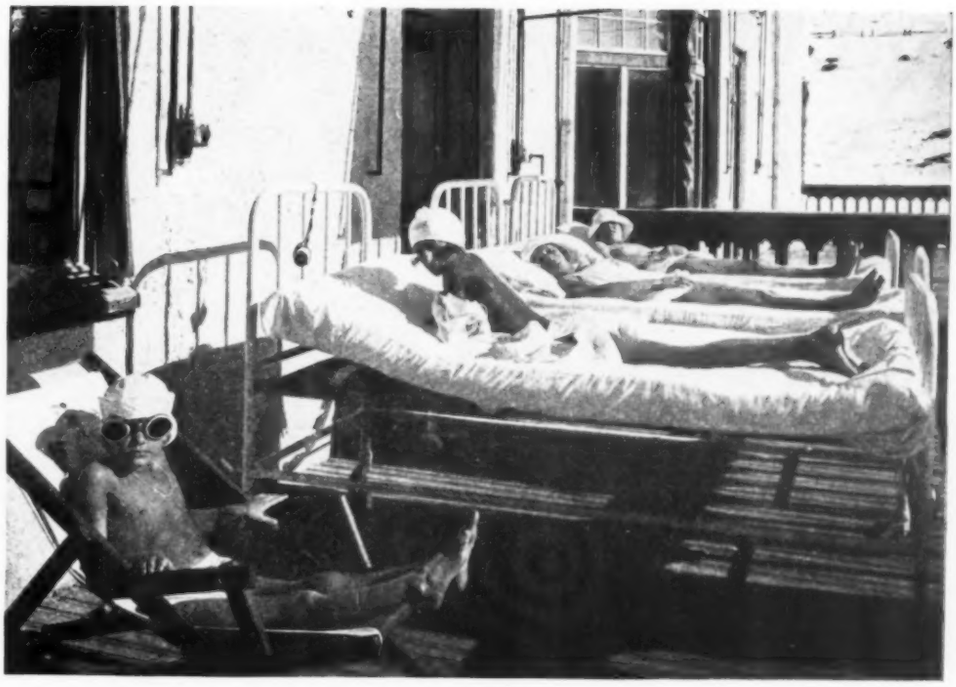
The total area occupied by the institute is 13,150 square meters, which includes the cloisters, the driveways and the so-called *parte monumentale*. The institute proper covers a space of about 11,000 square meters. The hospital has a ground floor, an upper story and a basement. In the basement are the boilers, the motors and the dynamos. There are likewise immense storerooms for various supplies; also cellars and a cold-storage room of considerable capacity.

Sport activities in the snow are one of the most approved forms of therapy.

In the west end of the basement, occupying a very large space, is the kitchen, which is amply provided with modern machinery and utensils. A dumb elevator serves to carry food to the first floor. Adjoining the kitchen is a large storeroom for reserve food supplies, provided with refrigeration.

On the ground floor, near the main entrance, are the ambulatory clinics, the offices of the management and the administration and several reception rooms,

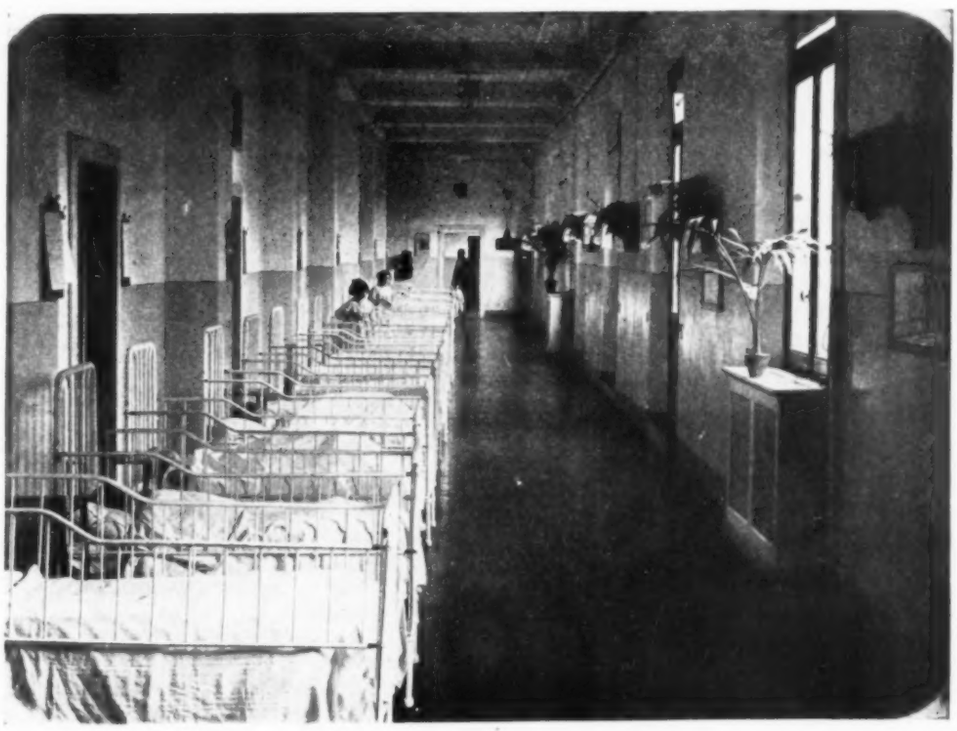
affording a pleasant view of the surrounding country. On entering the building one observes on the left the pharmacy and the distributing center for supplies. In the first cloister are the immensely large rooms of the gymnasium, the room containing the exhibit of plaster casts, the dressing room, and the magnificent marble-lined operating room, equipped with projection apparatus and with the most modern surgical instruments, most of which are made in the workshop of the institute. In this operating room are held the lectures to the students of the orthopedic clinic of the University of Bologna where Dr. Putti is a professor.



The Codivilla Heliotherapeutic Institute showing one of the many verandas for sun treatment.

In the central cloister are various departments: hydrotherapy, diathermy, electrotherapy, heliotherapy, the museum of anatomy, the exhibit of prosthetic apparatus, the apartments of resident physicians, the cloakroom and the lavatory. Just opposite is the room containing the clinical archives, in which is filed the case histories of all the patients of the institute since the day it was opened, classified according to diseases and the year of admission, with numerical references and cross references, that enable the searcher to find what he wants without delay. One section of the archives is reserved for the clinical record cards of the soldiers cared for during the war.

At the left is the histologic and analytic laboratory, with quarters for experimental animals, the photographic cabinet and the photographic and roentgenographic archives, where, in enormous cases, are preserved the complete records that go with the clinical histories, neatly executed and carefully arranged by a competent roentgenologist. A separate wing of the ground floor contains various storerooms and laboratories connected with the details of management.



The so-called cradle corridor of the pediatric department.

Extensive grounds almost surround the institute, and there is a large garden with many old trees, where the patients can enjoy the marvelous panorama of the city and the enchanting view.

In addition to the main staircase, four stairs lead up from various remote points of the ground

floor to the upper story, while a suitable elevator serves to transport the patients in their wheel chairs or in the proper litters.

The upper story comprises the pediatric department; the sickrooms of the first and the second class; the rooms of the third class (wards of the state and non-paying patients) divided into two sections, one for men and one for women; the apartment of the director of personnel; the roentgenographic room and the library, sumptuously furnished and adorned with many beautiful paintings of the school of Guido Reni. A richly decorated dining room for patients of the first class has adjoining it a beautiful rest room and reading room combined, which opens on to a large balcony over the main entrance, from which there is a fine view of the main driveway and part of the panorama of Bologna. Another dining room near by is for the use of the resident physicians. The patients of the second class also have a beautiful dining room, which overlooks the *chiostro maggiore* or larger cloister.

Ensemble view of the *aula magna*, the Humbert I library.

All these rooms adjoin an immense upper corridor, the *corsia superiore*, as it is called, which is 162 meters long, where the patients in inclement weather can take their walks and exercise, using such supports or wheel vehicles as their condition demands. Along this corridor are also the apartments and the refectories of the nurses, the motion picture hall (for scientific purposes and for the diversion of the patients), the billiard room and other reception and recreation rooms that will be opened soon, together with new sickrooms, in order to comply with constant requests received from all parts of the world.

At one end of the *corsia superiore* is the way leading to the Church of St. Michael in Bosco, which is always open to patients. Every Sunday and on fast days they may attend divine worship. On these occasions the general public also is admitted. An excellent pipe organ adds to the pleasure of the services.

The hospital is well arranged and excellently organized. The private rooms, first and second class, are provided with a stationary wash-bowl with hot and cold running water, good illumination, a service bell, a thermophore and apparatus for thermomassage.

Persons who accompany patients are permitted to stay in the institute at the rates established for the patients.

An ample telephone service connects the various departments of the hospital, and the hospital with the city and with long distance points.

Connected with the institute is the Officina Nazionale di Protesi, for the manufacture of prosthetic apparatus, which was established in 1915, under the direct supervision of Professor Putti. This workshop produced during the war the greater part of the prosthetic apparatus needed by our wounded and maimed soldiers. It furnishes supplies to seventeen provinces and has four agencies in Italy for the work of adaptation and repair.

The products of the workshop, which came into existence through the urgent necessity of meeting the demands of war, have been rapidly perfected and are now highly appreciated not only in Europe, but also in North and South America, where our patients who have emigrated, and our technical publications, have made them known at their true value. In addition, the workshop has distributed throughout the world a large number of surgical instruments that are the outcome of the creative genius of Professor Putti, whose name they bear. More than a hundred skilled workmen are employed in the various departments in the task of furnishing the maimed with the means of locomotion and with tools for work, thus enabling them to become self-supporting. The technical director of the workshop, Sig. Fusaroli, has also planned and constructed various types of apparatus, instruments and prosthetic accessories, such as the articulate hand that is known by his name.

In the midst of glorious memories of history and art, the patient who comes to St. Michael in Bosco to be treated for his maladies or to have his deformities corrected, finds here comfortable and quiet surroundings, which, from both the physical and moral standpoint, are well adapted to make his stay pleasant. Here, in this quiet retreat, in this peaceful atmosphere that seems still to partake somewhat of the old monastic régime; in the contemplation of the magnificent panorama of Bologna; in the enjoyment of the skillfully arranged walks of the garden, amid the luxuriant vegetation of the flower beds and the protecting shade of the century-old trees, his spirits revive and he finds his condition improving from day to day, without realizing that he is living in a hospital. This is the general impression of the patients, and, not infrequently, being well satisfied with the results of their treatment, they leave, on their departure, goodly sums with the management for the benefit of those who, in later years, may need to come to the Rizzoli Orthopedic Institute. What is true of the adults who visit the institute is true also of the children.

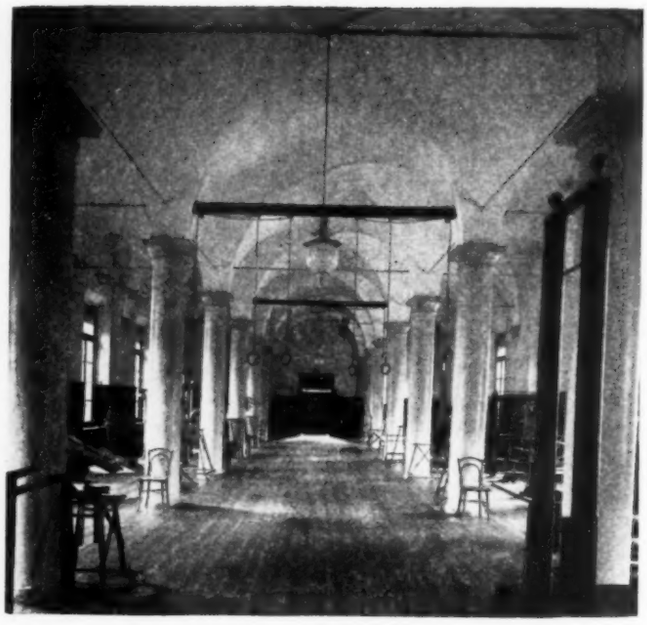
I have not spoken of the assistant physicians. The older men are of the school of Codivilla; the younger men are almost all pupils of Professor Putti. All of them are worthy collaborators in this great philanthropic work. They are proud to share the responsibility and the honor, and to develop their capacities under the guidance of their esteemed and beloved chief. Merely to serve as a physician does not suffice here. One must produce, write and take part in congresses. Therefore, when they have finished their long day at the hospital, you see them in the evening and ofttimes late at night, bent over their books in our magnificent library, or working in the laboratory, intent on unraveling the secrets of nature by means of the microscope, which has for them an irresistible fascination.

The Rizzoli Institute has for its main purpose orthopedics, but not in the narrow, restricted sense of devoting itself exclusively to the correction of deformities in children, but rather in the sense of correcting and preventing, at any age, by mechanical, physical or surgical means, deviations from the normal form of the body, combating not only the effects, but also the causes of the abnormalities. Orthopedics presents a vast field of action in which the institute has been performing its beneficent work for more than a quarter of a century. The institute has a normal capacity of 250 beds, but in time of war this can be increased to more than 500 beds, by using for the wounded and the maimed the wide corridors, large parlors and other rooms, which under normal conditions, are used as passageways, for the library, the museums and for recreation purposes.

Mussolini visits the Institute (October 29, 1923). With him is Dr. Putti and other notables.

Two large rooms on the ground floor, in the first cloister, contain the apparatus for kinesitherapy. They are marvelously equipped and constitute in themselves one of the principal attractions for visitors. It is difficult to describe the humming and pounding, the whirling and swinging, of the endless and varied applications of physicotherapeutics. There are so many Zander and so many Schultess machines that, for convenience, they are referred to by

The long corridor on second floor is well lighted.

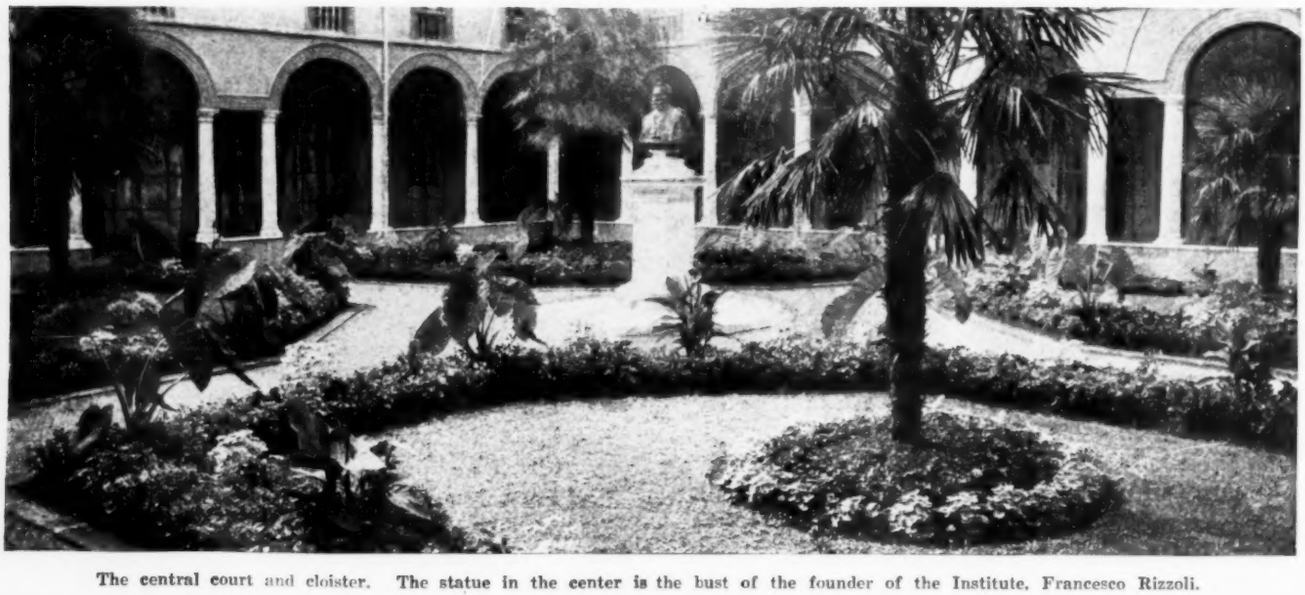


The Zander room: the department of kinesitherapy.

number. To give the reader some idea of the large number of patients who make use of this apparatus, it will suffice to cite some statistics covering the extent of its employment in 1923. The total number of persons visiting the Zander room was 19,444. There were 250 special visits made by patients from the ambulatory clinic; 110 pieces of orthopedic apparatus were designed; 306 plaster casts were made; 1,914 massage treatments were given and 486 applications with the Bier thermophore and 1,909 treatments with the electric thermophore were carried out. The total number of persons visiting the Schultess room was 4,643. There were 211 graphic reliefs made and 89 applications of the Bier thermophore and 3,219 massage treatments were given in the course of the year 1923.

In the physiotherapeutic cabinets 2,598 applications of electricity were made; 114 electric baths, 107 medicated baths, 3,140 common baths, 1,461 partial light baths, and 297 douches were given. Fifty-seven applications of artificial heliotherapy, 64 of the electric thermophore, 3,919 of the Bier thermophore, 6,816 massage treatments and 167 applications of diathermy were made. In addition, 986 plaster casts were removed. All these various operations, carried out under the supervision of medical specialists with the aid of a large staff of nurses, give a grand total for the year 1923 of 54,299.

The activities of the institute are evidenced by documents and records that are accessible also to outsiders, to whom they give a clear idea of the development in recent years under the guidance



The central court and cloister. The statue in the center is the bust of the founder of the Institute, Francesco Rizzoli.

of Professor Putti. Eight eminent medical specialists, Italian and foreign assistants; sixty-five nurses (of both sexes), and eighty persons employed in the various offices and services, form the worthy legion which accomplishes the various delicate tasks and constitutes the motor force, physical and mental, of this complex and active organization. If the personnel of the workshop for the manufacture of prosthetic apparatus be included, the total number of employees is about 270.

Growth in Quarter of Century

As the success and fame of the institute have increased the number of patients has grown commensurately. In 1899 the number of admissions amounted to about 20,000. The maximum was reached in 1922, in which year, owing to exceptional post-war conditions, the number rose to 160,235. In 1923 the admissions dropped back to 45,990. The total number of wounded and maimed soldiers cared for amounted to 4,100. The ambulatory clinic of the institute registered in 1923 about 5,850 patients who presented themselves for gratuitous consultations, ambulatory treatment and admission to hospital treatment. The average daily admissions to the hospital in 1922 amounted to 117, which in 1923 rose to 126. The number of patients receiving gratuitous treatment in 1922 was 439, which in 1923 rose to 528, the total number of days' treatment amounting to 9,573.

In 1923 the surgical department had to its credit 280 surgical operations. In addition, 2,388 plaster casts were prescribed and fitted, and 138 ambulatory patients were treated.

The total number of roentgenographic examinations made exceeded 3,100.

The number of private medical visits made by the director amounted to 1,847, a remarkable figure in view of the fact that in 1923 Professor Putti took part in several orthopedic congresses held in Italy and in foreign countries.

Alessandro Codivilla, the predecessor of Professor Putti, after having helped to make known the great importance of the institute, turned his attention to a project that had long occupied his mind, the founding of a sanatorium for the treatment of surgical tuberculosis, where patients who had received the surgical treatment given in our hospital could obtain the after-treatment they required. He died, however, before the completion of this work.

Professor Putti took upon himself the duty of carrying out Codivilla's plan, and devoted himself to its realization with all his energy and enthusiasm with the result that the project is now an accomplished fact. In Cortina d'Ampezzo stands the Istituto Elioterapico Codivilla, 1,300 meters above sea level, already functioning with great success. The administration has used here a large part of the patrimonial estate. This is the first institute of the kind in Italy, but that it is filling a need and meeting the expectations of its patrons is shown by the constant requests for admission. This offshoot of the Rizzoli Orthopedic Institute is in itself deserving of a detailed description.

In closing this brief account we wish to invite any American scientists or tourists who may come to Italy, to pay a visit to our institute in Bologna, where they will be received with the most cordial hospitality, and where, if they let us know of their visit in advance, they can always attend the lectures and the operations of the director.

HOW TO REFINISH METAL BEDS

In spite of the durability of the present day enamels, the constant wear to which hospital beds are subject often results in cracking or chipping the finish of the metal. This makes unsightly mars on the furniture and exposes the metal to the corrosive elements of the atmosphere.

Among the several accepted methods for refinishing metal surfaces the following has proved the most simple and, in the majority of cases, the most successful.

White or ivory. If the crack or chip in the enamel has not reached the basic metal, the spot to be touched up can be refinished by first rubbing with No. 00 sandpaper and then applying a coat of especially prepared air drying enamel.

If the defect is such that it is necessary to go to the steel, a coat of extra heavy primer should first be applied. This will build up the spot that is cut through. After allowing this primer to dry thoroughly, the specially prepared air drying enamel may be applied. This same treatment may be used in touching up any color of enamel finished beds.

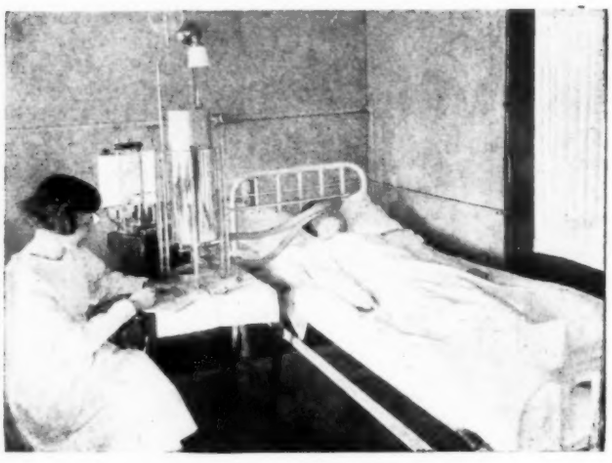
Vernis martin. Sandpaper and clean the spot or spots to be refinished. Apply a coat of bronze, mixed with a drier. After the bronze has dried, apply a coat of color varnish that will match as nearly as possible the color of the finish of the bed.

Wood finishes. Sandpaper and clean very carefully all defective spots; then touch up with the first coat, or ground color. When this is dry, apply a coat of glaze, and while the glaze is still wet apply the graining color and blend out with a small hair brush to give the natural wood effect. When thoroughly dry, apply a thin coat of varnish. After the varnish has dried, cover the spot with a little rubbing oil and pumice stone. If the mars are quite deep, rub the spots several times, then touch up with a second coat of varnish and rub again. If the defective spot is large enough to spoil the grain, comb with a steel graining comb while the glaze is still wet.

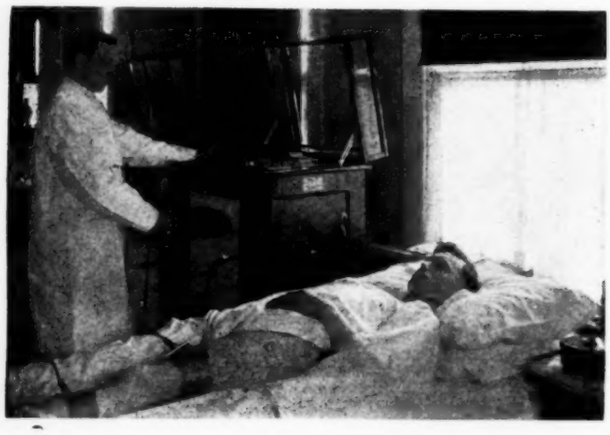
Within the past year the city of Los Angeles, Calif., has established a community chest with a fund of $2,500,000 for the support of worthy charities. Stock has been taken in the project by all charitable activities of the city.

A Class Putting Theory into Practice in the Diet Kitchen.

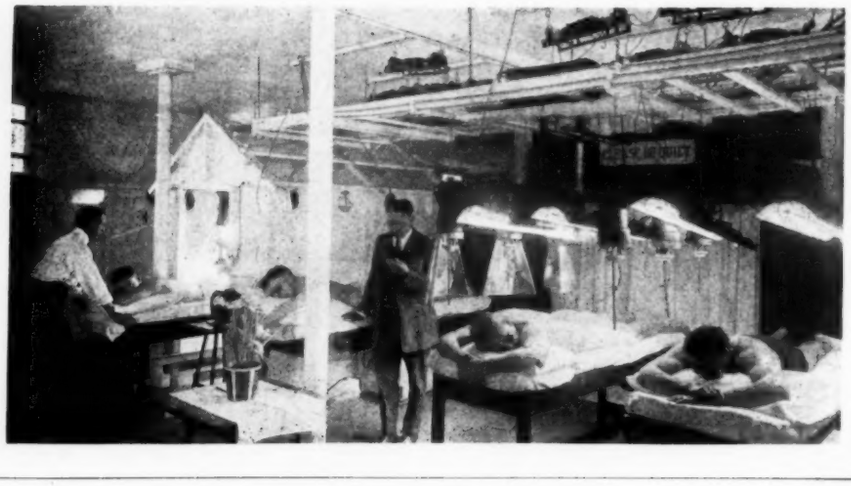
Special Departments Now Essential to the Complete Hospital



A Patient Undergoing a Metabolism Test—A Process Unknown a Decade Ago.



Regardless of the Weather Sunlight is used to Treat Patients by Means of the Quartz Lamp.



Diathermy Treatment Is Now Utilized in Many Hospitals.

CONSTRUCTIVE FINANCING—NOT CHARITY—BUILT THIS HOSPITAL

By S. G. Davidson, Superintendent, Butterworth Hospital,
Grand Rapids, Mich.

FORTY-FIVE years ago the parishioners of St. Mark's Episcopal Church, Grand Rapids, Mich., decided that as a church they were in duty bound to furnish a home for the indigent of their faith, and that it was becoming that the aged should be taken care of properly and comfortably. Accordingly such a home was secured and equipped.

The idea was most commendable and while the home was not a monetary success, it was an excellent work and much appreciated. Later it was decided that the work should be extended to cover the sick of the Episcopal church and forthwith a large building was purchased and the name broadened to "St. Mark's Home and Hospital." While not large the work was a worthy one and one of the men of the community decided that it was fitting he should contribute a portion of his wealth so that a modern building could be erected. He was Mr. Butterworth and his gift of $13,000 in addition to the land was a large one at that time.

After four years St. Mark's Home and Hospital came to the conclusion that better work could be accomplished if the sectarian aspect was removed and the hospital became a general one. This was done, but the institution continued under the old name for a year. It was then changed to Butterworth Hospital, now a general hospital of 270 beds and the largest in the city of Grand Rapids.

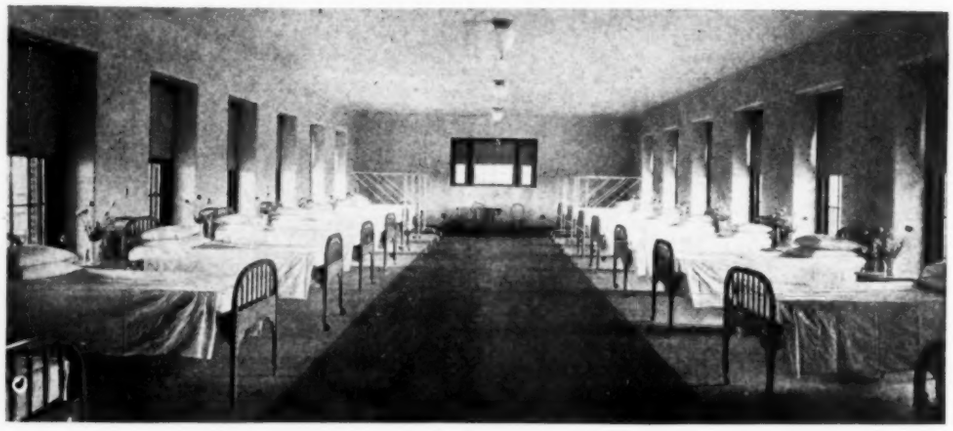
There were eleven trustees of the Butterworth Hospital three years ago and the bed capacity was 135. Now there are twenty-eight trustees on the board, plus the superintendent, and every one of them is not only interested, but actively engaged in some of the various phases of the work. It is of these twenty-eight men, their relation to the new hospital and why they are active that this story tells. It is also written as a standing example of what any community can do toward raising funds provided the plan is engineered properly.

The Vision of the Board President

Butterworth Hospital is fortunate in having as the president of its board of trustees a man of unusual vision and business acumen. More than fifteen years ago he foresaw that the hospital's needs were not to be met by building additions. Of his own volition he started to assemble a plot of ground directly opposite that on which the hospital stood. In time he completed the assemblage and with the completion he proposed the commencement of a new hospital and backed up the proposition by contributing the site, valued at $250,000, and in addition headed the campaign list with the generous sum of $500,000 in cash.

Butterworth Hospital, Grand Rapids, Mich., seen from the street.

The board of trustees met, heard his proposition, studied the situation and decided to raise enough to erect a hospital that was to cost approximately $800,000. A few informal luncheons were held and others of the city called in, among them the publishers of two of the newspapers of Grand Rapids. These men were of the opinion that it was an impossibility to raise the amount, even with the president's gift as a nucleus. It had never been done in Grand Rapids, and they felt the city was not large enough to respond to such a proposition and that it would meet with a cold reception. There were others in the community, however, who thought otherwise and it was decided that it would be better to try it anyway and see what would happen.



The wards are spacious and airy.

Accordingly a campaign was mapped out, not along the lines of begging for money, but rather offering an opportunity to help those who needed help. Weeks before the drive was actually started the three newspapers of the city entered into a publicity campaign in which the idea was always put forward that this was Grand Rapids opportunity to do something ennobling.

An attractive private room.

The drive opened a week before Thanksgiving Day, 1922, and ended at Wednesday noon. The sum set as needed for the hospital was a million dollars. Half of this had been contributed through the generosity of the president of the board. The other $500,000 was to be raised by popular subscription from the community as a whole.

When the receipts were counted there was a sum of $689,000 and not one begging letter had been sent out. Teams had been organized, business men had been interested in the proposition and daily luncheons had been held at the Pantlind Hotel. Publicity had been used and some literature mailed, but most of the results were due to the work of the teams, fostered by the eleven trustees and the superintendent.

After Grand Rapids recovered from its surprise, the trustees decided that if there was such interest in the hospital it would be well to continue the work and enlarge the board.

Twenty-eight trustees were later chosen upon the basis of their interest in the money-raising drive and their standing in the community. The new board was selected with care and then something very interesting happened. It was this: Each member of the board was put to work.

Nine committees were formed and each trustee made a member of a committee and the superintendent a member of each committee, ex-officio. Each committee was assigned definite work and

had a meeting of its own once a month, in addition to the monthly meeting of the board of trustees when the committees must report their activities. For example the administration committee goes over the records and expenditures with the superintendent; the house committee has charge of the personnel and the property committee authorizes all property purchases. Other committees function similarly.

Saving in Building Materials

The plans for the new hospital, begun before the money was raised, were completed and bids were asked. The trustees found that the lowest bid was $1,460,000, much more than the generous amount already raised. To meet this the superintendent and the trustees went over the specifications with the result that over $250,000 was "whittled" off in ways that were not noticeable and did not interfere with the vital needs of the hospital. For instance, a large savings was effected by doing away with some of the terra cotta work; plate glass, that had been specified throughout the building, was changed in some cases to double thickness glass; marble was discarded, paint specifications were modified; and the local contractor who was finally chosen was allowed to do the work without bond thereby saving $40,000 to the hospital. He was reliable and the risk taken by not carrying the insurance was small. Later, sub-contracts were eliminated and purchasing was done direct by the board and the superintendent, thereby saving enough to bring the bid down to the money available.

One thing that had to be sacrificed in the process of getting the specifications down to the money limit was the solarium, planned for the top floor. This was regretted by the board, but it meant a saving of $15,000 which was not to be ignored. The news of this elimination became known in the city and one of the women of the town came forward with an additional contribution of $15,000, given on condition that the solarium should be built.

The medical committee had as one of its first tasks the reorganization of the hospital staff. This was a delicate duty and one where diplomacy and tact were needed. It was accomplished, however, with evident satisfaction to all and with little friction.

The new staff was made to function in separate units but with one purpose—the good of the hospital as a whole. One of the newly elected trustees accepted his election with the proviso that he was not to be a figurehead but would be given work to do. This was a new spirit for a trustee, and it was not hard to find work for him. He was made chairman of the social welfare committee and immediately went to work getting all the information he could on the work in hand. He sent for reports, literature on the subject, surveys of work done in other parts of the country and every particle of available data. From this he extracted what was useful, discarding most of the "sob stuff" and all of the extraneous matter that could not be applied. Then he set out to learn what out-patient problems were present in Grand Rapids. He found out that to start an out-patient department would cost approximately $2,500 and that a director would be needed at a fairly large salary. At the next meeting of the board of trustees he outlined his plan, overrode possible opposition, and got action from the beginning. The department is now being formed and will be a new departure for Grand Rapids.

Another notable feature of the hospital planning was the engaging of an interior decorator from Chicago. He selected all the draperies, arranged and furnished the private rooms, decided upon the color schemes used in the solarium, lobby and other rooms, and generally gave the hospital an appearance that is soothing and in harmony with its surroundings.

How Other Hospitals Were Affected

Shortly after the Butterworth Hospital had been successful in oversubscribing its requirements, the other hospitals of Grand Rapids that needed money went after it in much the same manner and with the same plea—not "please help the poor" but, "here is your opportunity to do good." The Blodgett Memorial Hospital wiped out its deficit of $150,000, St. Mary's Hospital raised $384,000 and other organizations that had never had an idea that money could be raised were able to get a real, practical reaction from the community.

Perhaps the greatest value of the entire history is that Butterworth Hospital and the other hospitals of Grand Rapids now have the assurance that when they need money for improvements and additions the community is behind them to the last dollar. The sick and injured of that part of Michigan will be well taken care of when emergencies arise for the city has been awakened to its responsibility. Through the appeal the conviction has been driven home to the people that the hospitals logically belong to the community and should receive its whole-hearted support, not as charitable institutions or as beggars glad to receive crumbs thrown from the tables of the rich, but as respectable, integral parts of every self-respecting community worthy of the support of every citizen.

WHAT'S THE MATTER WITH OUR HOSPITALS?

By E. H. Lewinski-Corwin, Ph.D., Director, Hospital Information Bureau, New York

THE severest critics of contemporary civilization who would fain destroy almost every domain of it as corrupting the soul of man, make an exception from this sweeping condemnation for the estate of medicine. In this realm the service to fellowmen is the impelling impulse; all other considerations are but incidental.

The hospital occupies an important place in this realm and as time goes on more people come to its doors to seek relief in illness. In turn, the hospital as it grows larger in size and multiplies in numbers reaches out for a wider basis of support.

It may, perhaps, be of value to point out briefly the topics that are often discussed by the so-called man in the street in relation to the hospital. It happens that because of my position I often come in contact with expressions of opinion concerning hospitals. Sometimes the opinion expressed is vague and guarded; at other times it is well considered and voiced in either an emphatic or merely suggestive way, depending upon the make-up of the individual expressing it. To those who are closely bound up with problems pertaining to their particular institutions, it may be of interest and value to know how their problems are regarded by those on the outside. When crystalized, these viewpoints mould community policy.

A frequently discussed question is that of costs. Why is it that when rates for room and board in hospitals are so much higher than in hotels, the hospitals cannot make ends meet, particularly when the free work is decreasing and the percentage of pay work increasing?

The surmise is that hospitals are not run on a strictly business-like basis and that there exist too few checks on waste and extravagance, in comparison with private enterprises. The British who are forced to skimp more than we are, have devised various ways of reducing waste, and recently King Edward's Hospital Fund for London has published a report urging the substitution of quantity statistics for cost statistics. Cost figures fluctuate with changes in price and do not, therefore afford as reliable a gauge of consumption as quantities. The report presents a series of tables indicating how the quantity statistics might be arranged.

This is not an entirely novel idea. At the suggestion of Mr. Henry C. Wright, New York, the Department of Charities of the City of New York introduced, a decade or so ago, a similar method as a guide for the purchasing department in connection with food requisitions, and during the late war use was made of these tables in various connections.

The strict requisition system and unit cost accounting are not found generally in our hospital organizations. The public demands that the trusteeship of the hospitals be discharged with a keen sense of responsibility for strict enforcement of business methods in the management of hospitals.

Sick people and their relatives and friends will never get used to the indifference of nurses and other officials in hospitals. No other single factor makes so many friends for a hospital as courtesy and considerateness and many enemies are made through a lack of these qualities. Yet hospitals where these qualities of courtesy and considerateness are prevalent are few, indeed. I know of only one hospital where the nurses, interns, and other employees are scored on the basis

The Outsider's Viewpoint

THE possibilities in the field of the hospital are enormous. The hospital itself is becoming more and more a factor of the first magnitude in the community structure. It is of the greatest importance that the evolution of hospitals should proceed with the least friction. In addition to the intensive study of the immediate and pressing institutional problems, which is obviously needed in every hospital, a certain amount of thought should be given to how these problems look to those who regard them from the viewpoint of the outsider. From year to year the hospital comes more prominently within the ken and experience of more people, and becomes a subject of their emotion, reflection and cerebration. The hospital has become a social institution. In this article Dr. Lewinski-Corwin puts before us the perspective of the hospital and all its varied activities as viewed by the average man.

of courtesy and given prizes accordingly. Sometimes it is the receiving clerk or the cashier who is gruff and inconsiderate and gives a bad impression of the hospital. Much as business methods are needed in hospitals, rigidity in insisting on certain rules cannot be regarded as really businesslike, for it hurts the hospital more than it earns for it in the way of income.

Collection of Advance Payments

I have in mind particularly the method of collection of advance payments. Recently a superintendent of a hospital wrote a sermon for the new and inexperienced executives and warned them against falling victim to the "parasitic disease which infests nearly all hospitals — delinquent accounts." In the course of this homily he very properly stressed the point that payments must be made one week in advance and urged that when a patient, after three or four weeks, has come to the limit of his resources he should not be given any quarter but should be transferred to a lower priced accommodation. "A transfer of this kind is not at all popular," he says, "but should at times be resorted to as a salutary example to others." As you see, the transfer is not meant merely as a businesslike procedure on the part of the hospital, but as a punitive device. All other patients in the hospital should be informed that this culprit engaged, let us say, a semi-private room in the hope that he would be in hospital only three or four weeks and would be able to pay his bills, but Providence was spiteful; he has to continue in the hospital, and, irrespective of his feelings, he is to be demoted to a lower priced accommodation, and everybody must be told about it, "as a salutary example to others." Such an attitude helps the patient to get well and makes friends for the hospital!

Another thing for which hospitals are often criticized is food. So many people complain that the food served in the hospital is poorly prepared and is cold when served. They point to hotels and ask why it is that when served in a room in a hotel you are able to get food hot, forgetting all the difference that exists in serving an occasional guest in his room and the whole institution.

It is true, however, that many hospitals are defectively organized for the proper distribution of food among the ward patients as well as the private patients, and that the cuisine is not always excellent. I wonder how many hospital cooks have followed the famous example of the chef of Louis XIV who committed suicide when the *sauce mousseline* was half a tone off tune.

I should also like to stress the importance of scientific dietetics in relation to the treatment of disease, and particularly of diseases associated with disturbances of metabolism or renal and gastric diseases. There are few hospitals where the importance of scientific dietetics is fully appreciated and where proper educational guidance of the patients is attempted.

Only the other day a man wrote an indignant letter in answer to an appeal for a contribution for hospital purposes. He pointed out that he had been a contributor to hospitals for many years, but refused to continue his benefactions because recently his wife had been taken ill and her physician, who evidently had no hospital affiliation, was unable to take care of her in a hospital. This man was surprised to learn that hospital privileges are, as a rule, limited to selected groups of men. There is need of repeated explanations concerning the impossibility of proper staff organization and control over the medical and surgical work, when hospitals are run as medical hotels open to any one who applies.

Privileges Should be Extended

There is, however, need of some reform in the present practice. More men should have hospital affiliation than the present rigid system permits. There are several forms of organization which would permit of greater elasticity without disarranging the fundamentals of the present system. The plan here described provides for a staff hierarchy consisting of four ranks, the two upper ones carrying permanent tenure of office and the two lower ones a limited period of association with the hospital. It links up closely the work in the out-patient department with that of the hospital.

Let each physician entering out-patient service understand that he is expected to devote eight years to dispensary work; this time to be divided into four periods, each of two years' duration. During the first two periods his work is to be limited to the out-patient department exclusively; during the second two terms his time will be divided between the hospital and the dispensary. As he enters upon the third term of his service in the out-patient department, he simultaneously begins his first term in the hospital as an assistant visiting physician of the lowest rank. In two years he becomes the chief of the out-patient clinic and graduates to the next highest rank in the hospital. After eight years of service during four of which he held rank on the visiting staff of the hospital, he automatically steps out of the hospital, without any stigma attaching to this retirement, enriched by the valuable association with the hospital and by the experience gained in supervised team work. If he be an exception-

ally able man he will be noticed, and when a vacancy occurs on the permanent staff he will probably be called upon to fill it.

Such a plan, with modifications to suit various situations, would enable a larger number of men to form hospital connections than is now feasible; would render dispensary work more worth while and sought for; would link the out-patient department more closely with the hospital, with resultant benefit to the patients and the community and would raise the general standard of medical practice in the community.[1]

The hospitals can become more closely identified with the community, particularly in smaller cities, if they will throw open their diagnostic laboratories for the accommodation of private physicians, and will in every other way cooperate with the physicians for the best interests of every one concerned.

Facilities for Use of Practitioners

The fifth annual report of the Voluntary Hospitals in Great Britain makes a point of this. They strongly recommend that the general practitioners of an area should be consulted "with the object of ascertaining whether there are any means that can be taken by the hospital board to assist them in the diagnosis and treatment of their patients, such as placing at their disposal bacteriological, radiological, biochemical, and other methods of scientific investigation that can best be provided at a general or special hospital."

There are some people who in their rash moments like to indulge in statements like one recently expressed, to-wit, that there is no more poverty in the United States. Any one familiar with the relief agencies will hardly subscribe to this statement. At the same time, we have suffered in the last decade from less unemployment than in any preceding decade, and general prosperity has been on a satisfactory level. The problem of providing hospital care for those who are accustomed to using the general wards of a hospital is not an acute problem at the present time. The acute problem is in accommodating the people of the middle class, who, because of a higher standard of living, cultural and intellectual refinement eschew the associations of a public ward and of free medical service. The prevailing rates for hospital accommodations and nursing service, as well as for medical and surgical fees, are such as to create a serious problem for the people of this class when serious and protracted illness develops.

1. "The Dispensary Situation in New York City," summary and recommendations of survey made for the public health committee of the New York Academy of Medicine. *Journal of the American Medical Association*, February 27th, 1920.

A study of bills selected at random from a number of hospitals in New York City was made in connection with a survey of the hospital situation in greater New York by the public health committee of the New York Academy of Medicine, and attention called to the economics of sickness.[1]

The question of provision of moderate priced hospital facilities is a matter of paramount importance. How it should be met, I am not prepared to say. This matter ought to receive more discussion than it has had. Should the hospitals offer their facilities to this class of patient below cost, and also restrict physicians' fees? Or should a method be provided by some sort of group insurance whereby these contingencies could be met on an entirely business-like basis, free from any charity?

This raises two other questions: first, what is the rock-bottom hospital cost that would provide all the medical necessities as well as such comforts as the sick require? Second, is it fully in consonance with the best policy to make the private pavilion a money maker for the hospital, and in this way indirectly charge the private patients with the cost of maintenance of those who either pay nothing or less than cost? I am not prejudging these matters but am merely putting the questions as they appear to one who looks at them from the standpoint of a student and observer.

Closer Tie-up With Convalescent Homes

I believe that in this country we have made a great contribution to hospital care in that we are interested not only in the fate of the patient while he is in the hospital, but also after he leaves. We often follow him to his home; we help him to readjust himself after his illness; we inquire into the health needs of his family. We have not, however, as yet, endeavored to link the hospital sufficiently closely with the convalescent home and the institution for the care of the chronics. A closer union between hospitals, on one hand, and preventoriums, convalescent homes, homes for the care and reclamation of chronics, on the other, is a thing to be worked out in the near future. The scientific interest in "end-results" may accelerate the process, which will be of ineffable value to the community.

Among the recognized functions of the hospital is the advancement of medical and hospital science. We have been particularly negligent in this respect. We have not educated the public to the importance of that phase of the work, and we have not instilled in many hospital staffs the necessary scientific spirit. The postmortems, for

1. *The Hospital Situation in Greater New York*, G. P. Putnam's Sons, New York, 1924.

example, are very few in number in many hospitals.

The medical and social service records of many hospitals are utterly inadequate. Because of their incompleteness all the labor spent on them is largely wasted. It is much better for a hospital that does not aspire to a scientific distinction to have a brief record completely filled out than to clutter up the files with numerous sheets of paper on which items of vital information are haphazardly filled out. In this as well as in every other branch of hospital and community work the practice of going through the motions of a performance without thought or thoroughness or interest in the work should be discontinued.

Hospitals can make contributions through a proper and uniform presentation of statistical facts. Take the case of the City of New York where 400,000 persons go through the hospitals annually. What tremendous value the compilation of the medical statistics relating to this mass of humanity would have, if it were properly done! I may say that a start in this direction has been made by the Hospital Information Bureau where a statistical demonstration embracing the data of several hospitals has been tried out for two years.

Scientific comparisons between institutions are extremely valuable and enlightening. Take a commonplace thing like the average days' stay, as an illustration. One is surprised to find in how many hospitals the average length of stay for certain conditions does not vary from year to year, and how considerably it often varies from hospital to hospital. On the face of it, the reason for this is that in some institutions it is a mere matter of practice or routine to keep certain cases a certain number of days. If comparisons of this kind for a large number of institutions were published annually, it would suggest various lines of inquiry and self-analysis.

SPACE REQUIREMENT AND ORGANIZATION OF THE X-RAY DEPARTMENT

The space in which to assemble and use the equipment of an x-ray department is one to which too often only scant thought is given according to Dr. James T. Case of Battle Creek, Mich., one of the leading roentgenologists of the country. Even in many of the larger hospitals today one finds all the different instruments crowded into such small space that it is difficult to pick one's way between the various pieces of apparatus. It is a wonder that we hear of so few accidents occurring in roentgen ray departments. Some of these few, however, have been tragic. In some quarters there seems to be a hold-over of the idea of fifteen or twenty years ago that the roentgen ray department, being more or less analogous to the photographic department, requires only one or two rooms for its functioning; and as new equipment has been acquired, it is thrust into the old cramped quarters. Hospital directors who begrudge the space demanded by the roentgenologist would do well to visit such institutions as the Battle Creek Sanitarium, the Mayo Clinic, Rochester, Minn., and the University Hospital at Ann Arbor, Mich., indeed, almost any one of the larger teaching hospitals, to realize the importance conceded to the roentgen ray as demonstrated by the generous space allotted to this department.

It may be more or less tentatively stated that a hospital of fifty beds should have at least 400 square feet of floor space devoted to roentgen ray work. Up to 150 beds, there should be not less than 650 square feet of floor space divided into rooms for treatment, roentgenography and fluoroscopy, dark room and office. Larger hospitals should have from 1,200 to 3,000 square feet, including treatment rooms, roentgenographic and fluoroscopic rooms, office, film loading and developing room, film consulting room, filing room, lavatories and waiting room, and a work room for mechanical development.

It would be axiomatic to declare that no amount of luxurious equipment will make up for the lack of a competent physician roentgenologist, or that the roentgenologist cannot render a full measure of usefulness to the staff without adequate facilities. Furthermore, it is self-evident that the type and arrangement of the equipment will differ in the different classes of special hospitals; for the roentgen ray department is but one of the clinical diagnostic departments, and the proper perspective must be maintained according to the ability of the hospital board to equip and staff its various sections.

The hospital of fifty beds or more should certainly have a physician specializing in roentgenology. He may be only a visiting roentgenologist, having other work elsewhere; and in smaller towns he will probably be a man who devotes only part of his time to roentgenology.

When a Physician Is Needed as Roentgenologist

It is manifestly impossible and unthinkable to permit or expect anyone but a physician to undertake the interpretations of the roentgen ray findings, with any hope of transmitting to the clinician all the help which the roentgen ray is capable of giving. There have been some notable exceptions to this statement, but they have numbered very few indeed; and with the ever-widening field of roentgen ray application, the usefulness of anyone but a graduate physician for roentgen ray interpretation is steadily decreasing. Even in the small community, where now each physician makes his own interpretations, it would be not only ideal but in thorough sympathy with the principle of hospital standardization and mutual cooperation between physicians thereby involved, if the agreement could be reached that one of the physicians in the community should devote special attention to roentgen interpretation and act as consultant in this capacity.

A hospital of 150 beds or more should not be considered completely staffed without a physician roentgenologist who devotes full time to his work. He may devote his services to more than one hospital, but his major time and thought should be devoted to perfecting himself in his roentgenologic work and to reaching out into new lines of roentgen ray development. He may spend only a few hours a day in the hospital, and the rest of his time in his office outside the hospital; or the hospital may wisely arrange for his private work to be conducted in the institution. Still larger hospitals should have the full time services of a physician-roentgenologist who may advantageously combine his roentgen ray work with radium therapy and the various surgical procedures that are more commonly involved in the application of radium.

WHAT LOCAL RED CROSS CHAPTERS DO FOR THE SICK OF THE COMMUNITY

ONLY those who appreciate the benefits of the modern hospital, with its provision for the care of the sick and injured, realize fully what hardships are endured in districts where it is absent. Of inestimable service in such isolated, rural areas are what may be called the long, emergency, extension arms of a hospital.

Together the American Red Cross chapter and the medical society formulate plans of one kind or another. Perhaps two or three beds are placed in the Red Cross public health nurse's office, so arranged that in imperative need they are available for an emergency case. From this headquarters mothers in their own homes are provided with the same skilled nursing care that the patient receives in a maternity hospital. And here are prepared sterile, obstetrical packages which may be bought, the money being refunded on the return of the articles when no longer required.

More ambitious arrangements are required by tonsillectomies. A place is secured, perhaps the upper floor of the court house. Community feeling is aroused and generous storekeepers cooperate with doctors and nurses, in providing cots, bedding, tables, chairs and other things. The rooms are transformed by Red Cross workers into an improvised hospital. Then the specialist comes from the city to perform the operations.

Different arrangements prevail in the case of overwhelming catastrophe. The Red Cross mobile disaster relief unit is prepared for service at any hour of the day or night. An S. O. S. means the prompt dispatch of special trains with doctors and nurses, and loaded with cots, bedding, surgical appliances, even portable x-ray machines on occasion, bandages, medicines and other equipment, supplementing overburdened local provision. Emergency hospitals, dressing stations and dispensaries are set up in various sections of the stricken area. Last March in the great Middle West tornado the Red Cross first aid car, which was near, became a hospital with fifty patients.

Who knows better than modern hospital staffs that here is work which should not cease. The greater the American Red Cross membership, the more it can do in this respect. Everyone enrolling between November 11 and 26 helps to maintain this extension arm service of the modern hospital in districts where it is most needed.

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The creed was first introduced in September 1924 and met with instant response. Since its introduction copies have been distributed in great quantities and it is expected that this demand will continue as new hospitals and nurses' homes are completed.

Inasmuch as the creed typifies hospital service as sponsored and furthered by the American Hospital Association, it was thought fitting that the rights to reproduce should be vested in its name rather than that of the publishing company.

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At a meeting held September 10, the board of trustees accepted the transfer and expressed its thanks to THE MODERN HOSPITAL Publishing Co., Inc.

A group of farm buildings at the Philadelphia Hospital for Mental Diseases.

HELPING THE MENTALLY ILL TO BECOME SELF-SUPPORTING

THE Philadelphia Hospital for Mental Diseases was originally housed with, and was in reality only a department of the Philadelphia General Hospital, which was at once a municipal hospital, a home and hospital for the insane and a haven for the feeble-minded and the indigent.

The continued growth of the city's population with its consequent increase in the number of patients to be cared for under each and all of these divisions, brought about a crowded condition in the Philadelphia General Hospital. This made it an imperative necessity to take steps to relieve the congestion and to plan with wider vision for the future need of the city with regard to its citizens whose physical or mental condition required that they should be cared for in the city hospitals.

This wider vision resulted in the purchase, about twenty years ago, of some 875 acres of farm land at what is known as Byberry, Pa., which lies within the corporate limits of the city of Philadelphia. This original tract of land was added to by subsequent purchases of adjacent farms which brought the acreage up to its present total of about 1,100 acres. Such buildings as were on the land at the time of purchase, mostly frame and comprising several small houses and some barns, were left standing and utilized at the beginning for the housing of the first patients transferred from the mental department of the Philadelphia General Hospital to the farm.

The plan as originally conceived was to separate the Philadelphia Hospital for Mental Diseases entirely from the Philadelphia General Hospital, and to construct on the farm land purchased a modern and complete hospital for the treatment and care of patients who are mentally ill.

This plan was adhered to and is now nearing fruition. Modern fireproof buildings already completed are at present housing more than 2,000 patients, while additional buildings that will provide accommodations for about 1,500 more are now under construction. Eventually the hospital will be enlarged to take care of 6,000 patients and equipped with laboratories, research department and every approved device for the scientific study and treatment of disorders of the mind.

Stimulated by the splendid and practical interest in the city hospitals shown by the present mayor of the city, the Hon. W. Freeland Kendrick, and of the director of public health, Dr. Wilmer Krusen, and the assistant director, Mr. Joseph L. Baldwin, all of whom have given largely of their time and thought in planning for the care of the city's ill and unfortunate, it is the intention of the city of Philadelphia to make its Hospital for Mental Diseases the peer of any hospital for the insane in the United States.

Heifers representative of the cattle raised on the farm.

But it is the purpose of this article to de-

scribe more particularly, though somewhat briefly, the hospital farm—its operation, its production and the results already achieved. As previously stated the farm comprises at the present time approximately 1,100 acres of which about 800 acres are under cultivation. Sixty-five acres of this land is devoted to a truck farm which is yielding a fine return in the quality, quantity and variety of vegetables produced. The following figures for 1923 give the actual production of some of the varieties grown on the truck farm:

Logs cut on the farm are hauled in this manner to the occupational therapy shop.

Beets	14,725	baskets
Cabbages	7,420	"
Carrots	7,800	"
Celery	24,566	stalks
Kale	1,003	baskets
Lettuce	37,967	heads
Lima beans	594	baskets
Parsnips	2,165	"
Pumpkins	806	
Rhubarb	58,188	bunches
Scallions	27,022	"
Spinach	3,325	baskets
String beans	1,260	"
Swiss chard	2,191	"
Tomatoes	2,486	"

In addition to the above, hundreds of baskets of peas, cucumbers, peppers, parsley, radishes and horseradish were raised during the year 1923.

For the larger operations of the farm the following figures for 1923 production may prove interesting:

Potatoes	4,850	bushels
Wheat	2,272	"
Oats	908	"
Mangel Beets	9,000	"
Field Corn	8,820	"
Corn Fodder	27,750	bundles
Straw	103	tons
Hay	450	"
Manure	2,000	"
Eating Corn	127,000	ears
Peaches	127	baskets

Some apples and pears were also grown, although in smaller quantities.

An average of forty head of horses is maintained on the farm in actual service and two tractors were used in 1923. Two new tractors have been added to the equipment during the year.

The beautiful woodland of the farm affords much enjoyment to patients.

In the dairy there is a herd at present numbering 190 head of stock comprised as follows: 83 cows, 7 bulls, 83 heifers, 17 calves. This is somewhat more than the census of the herd in 1923, the production figures of which follow: Milk 221,063 qts., cream 2,256 qts., veal 3,400 lbs., beef 2,226 lbs. A modern cooling and straining system, a separator and a pasteurizer are installed as part of the dairy equipment.

The poultry department gives the following figures for 1923: Eggs 10,046 dozens, chickens, 3,753 pounds, ducks, 390 pounds.

In the greenhouse the following potted flowers were raised in 1923: Geraniums 5,000, scarlet sage 2,000, Canna lilies 2,500, ferns 200, petunia 500, zinnia 200, snapdragon 200. Experiments were made on a smaller scale with a number of other varieties.

It is expected that the production figures will become materially higher, especially in the dairy and poultry operations. Through the untiring efforts of the assistant superintendent, Edward A. McNally, ably seconded by the head of the farm department, Henry Wellendorf, a much more efficient system has been instituted.

In the poultry department especial attention has been given the incubators of which there are ten and from which there were actual hatchings of a little over eight thousand chickens in 1924. An accurate record is kept of the number of eggs set in each incubator, the number eliminated by test and the percentage of remaining eggs hatched and raised. Some surprising figures developed as a result of the attention given this department by Mr. McNally and Mr. Wellendorf. Percentages of tested eggs hatched running as high as 95 per cent have been reached and a percentage as low as 75 is regarded as a calamity.

The distribution of the entire production of the farm is carefully planned and supervised. Naturally the Philadelphia Hospital for Mental Diseases itself, with its present census of more than 2,000 patients, consumes a considerable portion of the output and this affords a fine variety of fresh vegetables for both patients and employees during the course of the year. Other institutions of the city are also provided for, however, and a large share of the vegetables and eggs are sent to the Philadelphia General Hospital, the Philadelphia Hospital for Contagious Diseases and to the House of Correction.

When a patient is admitted to the hospital he is immediately given a thorough examination by the medical staff under the guidance of Dr. E. S. Barr, medical director of the hospital, to determine as far as possible both his mental and physical condition. If the result of the examination indicates that his mental condition is not unduly disturbed and that his physical condition is such that some sort of employment will not be harmful and may be beneficial, he is directed to a group or class of patients who are assigned to some particular work on the farm. A new patient thus joined to a group is closely observed by the attendant in charge of that group and reported upon by the attendant to the supervisor.

The medical staff meanwhile makes frequent and thorough examinations as to the effect of the work upon the physical condition and mental reactions of the patient. Experience has proved that many patients are not adapted to the work being performed by the group to which they are joined and as soon as this is indicated the patient is transferred to another class performing a different task. In this way a patient may be transferred to a dozen different groups before he is placed at a task that seems to awaken his interest. Once that happy result is achieved, however, he is definitely assigned to that particular work and encouraged to develop interest and proficiency in it.

The value of this method in the handling of patients afflicted with mental disorders cannot be overestimated. Its beneficial effect is attested to by the record of hundreds of patients released from the custody of the hospital either wholly or conditionally, and by many permanently cured.

One of the large barns of the farm.

THE RELATIONSHIP OF THE COMMUNITY TO THE COUNTY OR TAX SUPPORTED HOSPITAL*

By R. G. Brodrick, M.D., Director of Hospitals,
Alameda County Hospital, San Leandro, Calif.

OPINION varies widely in different portions of the country regarding the responsibility of the community towards its sick poor.

Over thirty of the leading states of the Union have enacted laws making it the duty of counties, separately or conjointly, to provide for the construction and maintenance of hospitals for general diseases, sanatoriums for tuberculous patients, and institutions for the isolation and treatment of persons with communicable diseases.

There has been no comprehensive survey made of public hospitals in the United States. As far as I have been able to determine, there are about one thousand municipal and county hospitals, of which the majority are classed as general, and among which are included 150 contagious disease hospitals, 125 infirmaries, or almshouses, 125 tuberculosis sanatoriums, and 75 institutions for mental diseases.

There is the usual tendency towards concentration in the more populous sections, as, for instance, the six states of New York, Massachusetts, Pennsylvania, Ohio, California, and Texas, comprising 30 per cent of the population of the entire country, have over 33 per cent of the total number of municipal and county hospitals.

On the other hand, the nine Southern States of Alabama, Arkansas, Louisiana, Mississippi, Florida, Georgia, Kentucky, North Carolina, and South Carolina, with 18 per cent of the population, have 7½ per cent of the total number of tax-supported hospitals. Approximately one-half of the counties in the United States have no hospitals.

*Read at twenty-seventh convention of the American Hospital Association, Louisville, Ky., October 19, 1925.

There is no institution in our Government that has been held in such contempt as the county almshouse. The public belief that it serves solely as a domicile for the care of the destitute and aged is, however, not borne out by fact, for according to the 1923 census, of the 78,000 paupers enumerated in almshouses of the United States, 36,700, or 47 per cent, had serious physical defects, and only 7 per cent were able-bodied.

The physical incapacities of these individuals are by no means due to the infirmities of old age. Such statistics as are available indicate that these institutions are becoming less used as homes for the aged, and in an increasing measure utilized for the accommodation of persons, who through illness have either been pauperized, or are suffering from chronic diseases and hence are not eligible for the free or acute service of private hospitals.

Every community should have the right to build, equip, and maintain a public hospital, if the majority of its citizens so desire.

Twenty states have already passed such enabling acts, all patterned, with various modifications, upon the Iowa law. In some states boards of supervisors have gone ahead without legal authority, realizing the pressing need and public demand, and have built community hospitals.

Small communities with a population of less than fifty thousand cannot be expected to support more than one general hospital. When a private hospital already exists in such a locality, and has been incorporated not for profit, but uses its earnings for hospital betterment, it should care for the indigent patients, for whom the community, as a whole, ought to pay. This financial aid

An Urgent Need

ALTHOUGH marked improvement has been made during the past twenty years in raising the standard of state and municipal hospitals, little progress has taken place, with but few exceptions, among county institutions for the care of the sick. However, a growing demand for better public hospital service is becoming evident; an increasing number of community hospitals are being established, and in many states these hospitals are available to all the citizens.

The question of the admission of pay patients to tax-supported hospitals in large communities, enjoying private hospital service, is still open to discussion. The purpose of the public hospital is primarily to care for the indigent sick. There is, however, a most pressing need that cannot be ignored for hospital facilities at reasonable rates for middle-class patients, the so-called "white collar brigade," who form the bulk of our patients.

must be based upon an agreed rate per diem for each patient, as courts have decided that lump sums cannot be appropriated from public moneys for charity work done by private hospitals.

On the other hand, if the community has established its own hospital out of public funds, it should serve the entire public who support it through taxation, when any of them need its service.

Such a hospital is best governed by a commission of three to five members appointed for special fitness by the county board of supervisors, or elected by the vote of the people.

Community hospitals should be general in type, receiving all patients requiring hospital care, including those infected with communicable diseases. Moreover, in the interest of economy, and whenever possible, such an institution should be operated in conjunction with a tuberculosis hospital, such as counties in most of the states are now authorized to build.

Convenient Location Important

For the convenience of the medical profession and public the hospital must be conveniently located, although with modern means of transportation there is no objection to a suburban site.

Every legally qualified physician should have the right to treat a patient in such an institution, the hospital charging the patient for services rendered, but having no interest in the financial affairs existing between physician and patient.

In communities having over 100,000 inhabitants, it is generally conceded that there is a place for both private and public hospitals, although they should avoid costly duplication in their fields of work, and together meet the hospital needs of the entire community.

Voluntary hospitals, supported by liberal contributions and maintaining high standards of service, educate the people and thus aid public hospitals in obtaining adequate appropriations from boards of supervisors, so that their work will not be inhibited. Likewise the contrast in the management of a well conducted, private hospital, as compared with a tax-supported institution, hindered by selfish interests, is apt to be sufficient to eliminate vicious political interference.

A person in moderate circumstances, depending upon a salary of approximately $150 per month, faces financial ruin if he or a member of his family develops an illness requiring prolonged and costly hospital, medical, and nursing care. Many city and county hospitals are giving splendid service in relieving this situation, by charging a rate adjusted according to the individual's ability to pay. I feel that voluntary hospitals could, no doubt, materially aid in solving this problem by eliminating the duplication of free service, requiring such patients to receive care in public hospitals, which would then be better conducted, and thus additional ward service could be provided, at moderate rates, or on a graduated scale of charges for the middle-class patient, who does not wish to accept free treatment.

I am convinced that patients in moderate circumstances suffering from chronic diseases are entitled to public hospital care at rates within their means, rather than either compelling them to be treated poorly at home and disrupt the entire family, or dissipate the family's savings through costly hospital care, and then turn the unfortunate victims over to the community to be indefinitely supported as paupers.

For similar reason, the county should provide accommodations in its tuberculosis sanatoriums for the middle-class who now find it well-nigh impossible to obtain sanatorium care for less than $125 per month.

In many state, county and municipal hospitals for mental diseases it has become an accepted custom, established by long usage, to charge the relatives of patients who are able to pay for hospital care.

Contagious Hospital Open To All

In a similar manner, any person, irrespective of social condition, infected with an acute communicable disease, should, in the interest of the public health, be eligible for treatment in the isolation department of the public hospital, and those who are self-supporting should be charged for hospital service as well as medical care.

Of the larger municipal hospitals much need not be said as they are well known to the majority of this audience. During the last decade great progress has been made in raising the standard of these institutions, many of which are now among the finest examples of modern hospital construction in the country. New York, Boston, Buffalo, Cincinnati, Cleveland and San Francisco, operating under the authority granted them in their charters, have assumed full responsibility for the care of their indigent sick, thereby relieving the remainder of the county of this problem, and these large centers have, in this way, materially raised the standard of hospital care.

Such hospitals have been placed by charter under the supervision of special hospital boards, trustees, or commissions, who at least are interested enough in the problem to serve usually without compensation. Civil service has been instituted, supplies purchased through competitive

bids and a visiting staff appointed from representative men of the community, who are in many cities associated with the medical college of a university.

Many of these hospitals are given a grade of scientific care that is comparable to that furnished by the best private institutions of the country. Here, unfortunately, the fine work ceases, for when we consider the county as a whole the entire condition changes, with but few exceptions.

Average County Hospital Antiquated

The average county hospital, in the majority of states is an old, dilapidated, poorly run institution, generally under the domination of the supervisor in whose district the institution happens to be located. It is the common practice to refer all matters, such as appointments, improvements and policies to him, and he is usually unprepared by training to meet these problems. The superintendent is apt to be a recent graduate in medicine, who, through influence, has been appointed in order that he may become skilled in surgery. He has no special interest in hospital administration; these matters are usually delegated to a graduate nurse, or, more commonly, to a matron, who through long service has become the real superintendent of the institution.

There is no visiting staff, seldom a consulting staff; no training school; rarely even graduate nurses; no dietitian; and often no laboratory; hence, no scientific diagnosis or treatment.

In an endeavor to present some method to correct these evils, may I be permitted to briefly refer to what has become known as the Alameda County plan of operating public hospitals. This has now been in operation for eight years.

Let us look back over this period, briefly review conditions existing at that time, recall why this plan was created, what kind of an organization was adopted, and what has been accomplished. Such reflections should serve as guideposts for the future and may be of interest to other communities facing similar problems.

Conditions existing prior to 1917 were bad. The hospital consisted of a number of dilapidated buildings, fitted with obsolete equipment. The sick, the aged, and the young were all herded together in this common institution. The standard of professional care was low; it was difficult to develop, or hold, a desirable staff, and the sick suffered from neglect. As a result, derogatory articles were published in the press, public opinion was aroused, and interested citizens petitioned the board of county supervisors to remedy the situation.

Thereupon, the state board of charities was requested to investigate conditions and in accord with the recommendation embodied in their survey an ordinance was adopted, creating a special commission of seven members to whom were delegated the administration and control of the county institutions for the care of the sick.

Commission Well Chosen

The members of this commission, each of whom possessed some special knowledge that would be of value to the work, included a business man, an attorney, the chief surgeon of the Emergency Hospital, a university professor, a labor leader, and one woman, a college president.

Investigation and study clearly revealed that the problems resolved themselves into the following:

First, care of the acute sick, including communicable diseases.

Second, care of the chronic sick, including advanced tuberculosis.

Third, care of curable tuberculous patients.

Fourth, provision for convalescents.

Fifth, provision for the aged.

Each of the foregoing required different standards to obtain the best results at the minimum cost. It was, therefore, decided to create the following institutions:

First, health centers, of which there are nine in the principal towns of the county. These centers, in addition to their other functions, serve as out-patient departments and the initial point of contact for hospitalization of all ambulatory patients.

Second, a large general hospital for acute medical and surgical patients, situated near the center of population, where treatment can be obtained without delay and discharge occur as quickly as possible.

Third, an institution developed in the country for the chronic sick, the aged, and for the convalescent. Here, farms, gardens, shops, and industries exist, so that the inmate and convalescent may, wherever possible, through their labor reduce the cost of maintenance of the whole hospital system to the minimum.

Fourth, a sanatorium, located in the foothills of Livermore Valley, where curable cases of tuberculosis can be treated by proper means and in the least time possible.

Fifth, a preventorium for children under the sponsorship of the Arroyo Sanatorium.

All of these have been developed, and today the citizens of Alameda County, and the supervisors who made this work possible can judge if the results justify the efforts that have been made toward better care of the sick.

MODERN PLANNING AND EFFICIENCY METHODS FEATURED IN NEW OUT-PATIENT DEPARTMENT

By Coolidge & Shattuck, Architects, and John J. Dowling, M.D., Consultant,
Boston

ON OCTOBER 28, 1924, there was dedicated in the city of Boston, with appropriate ceremonies, a new building for the treatment of out-patients at the Boston City Hospital. A few days later the building was opened for patients.

In the former quarters the out-patient department of this hospital has treated an average of about 500 patients daily. The new building has been planned with the aim of making the out-patient department a larger and more distinctive feature of the hospital work than in the past. To this end it has been equipped with every known device for the treatment of out-patients and its capacity is fully four times that of the old quarters. In order to make practicable the change from the old building to the new, without confusion or undue pressure upon the staff, and because of changing from a decentralized to a centralized system of records, it was necessary to move one department at a time over to the new quarters, so that all departments were not active in the new building until May 1, 1925. The number of visits per day has already increased to 800. This is less than one-half the capacity.

The out-patient building of the Boston City Hospital.

The new building stands at the corner of Harrison Avenue and East Concord Street, on the site of the old out-patient department building. Portions of the old walls were conserved and extensive additions made to them. The first floor was dropped to the street level, two stories added, and the interior entirely rearranged.

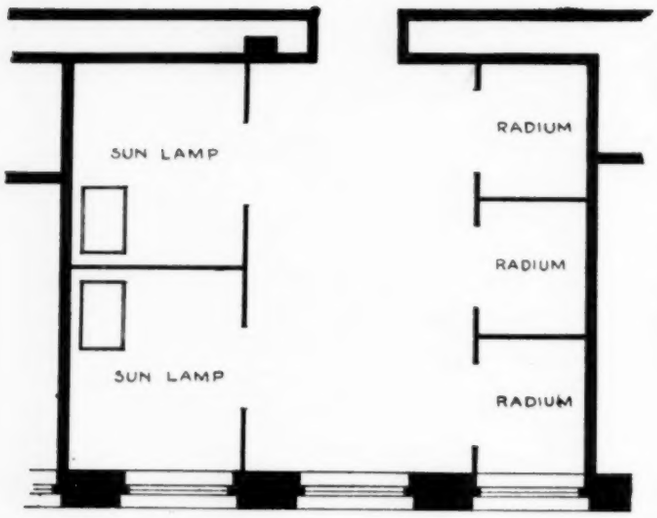
The exterior of the building is of brick and stone in simple design, with a flat roof. There are seven floors, six and a mezzanine. The building is 120 feet long on the Harrison Avenue side, 156 feet on the East Concord street side, and 42 feet wide.

The new floors and extensions are of modern fireproof construction, consisting of steel columns and beams, which, with the exterior brick walls, support the reinforced concrete floor construction. Dropping the old floor to the sidewalk level made it possible to construct a mezzanine floor in each wing, leaving in the central portion a high entrance hall that has direct connection with the two streets, so that the patients enter on Harrison Avenue and are discharged on to East Concord Street. From this entrance hall an underground tunnel provides direct covered connection.

The floors of all toilet rooms, waiting rooms, entrance hall, cleaners' closets, telephone booths, stair halls and rooms for surgical dressings, irrigating, operating or urine specimens, are of terrazzo. The floor coverings for the remainder of the building are of battleship linoleum.

The bases in all portions of the building are terrazzo, of the type used in Massachusetts General Hospital.

The walls of all toilets, cleaners' closets, and urine specimen rooms have terrazzo dadoes; the walls of all other rooms have dadoes of hard plaster. The balance of the walls and all ceilings are finished in plaster.



DETAIL OF SUN LAMP & RADIUM RMS.
SIXTH FLOOR
SCALE OF FEET

The door frames throughout are of steel with rounded corners; they are finished flush with the plaster walls. The doors are of oak, flush on both sides without panels.

The windows are finished with the minimum amount of wood.

All the walls in the building are finished in enamel to a height of six feet; above this and on all ceilings the finish is lead, oil and zinc paint. The woodwork is stained and varnished.

Fireproofed Elevators

The upper floors are served by two electric passenger elevators and three staircases that are fireproof.

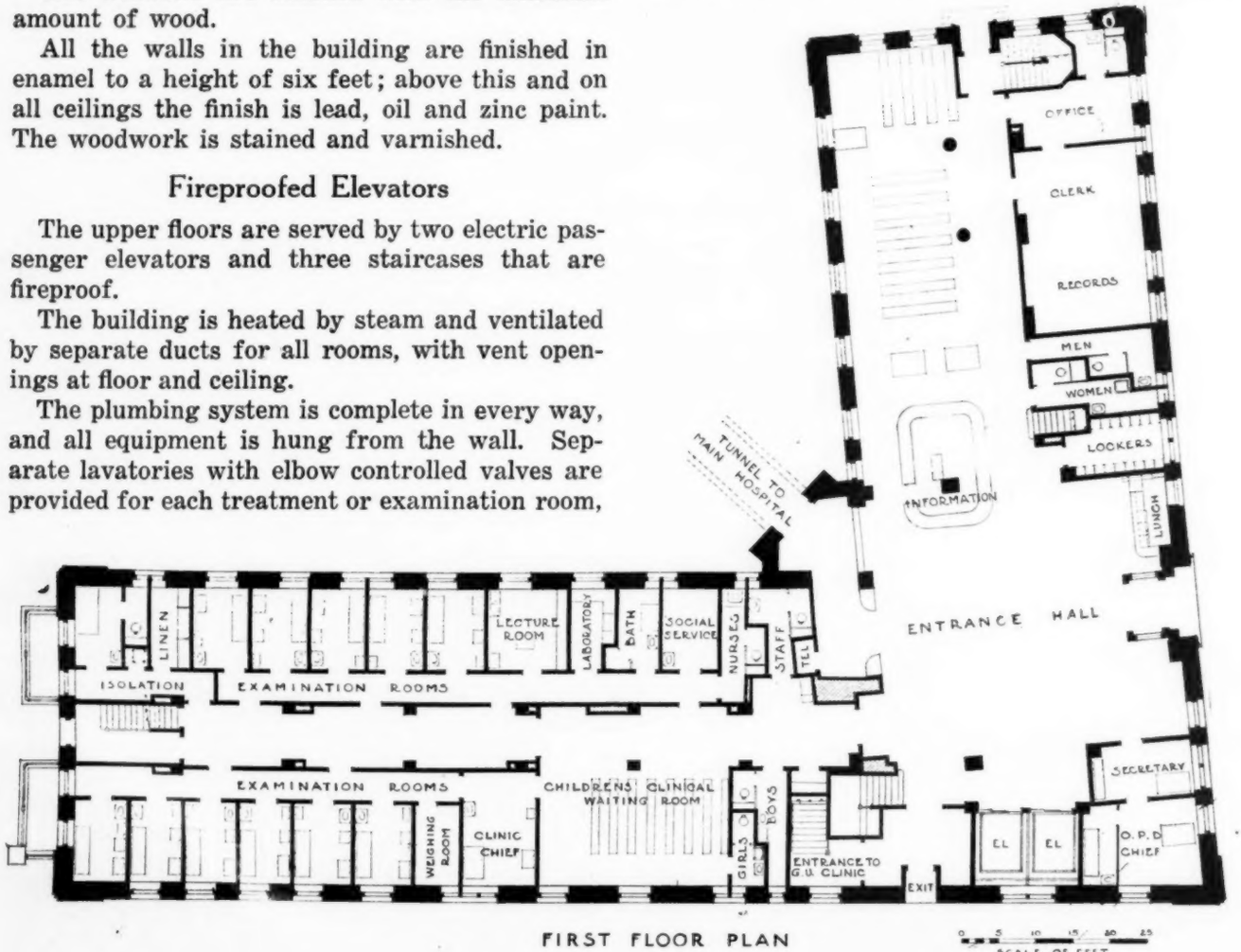
The building is heated by steam and ventilated by separate ducts for all rooms, with vent openings at floor and ceiling.

The plumbing system is complete in every way, and all equipment is hung from the wall. Separate lavatories with elbow controlled valves are provided for each treatment or examination room, with special sinks where the nature of the work requires it. These, with the connections for sterilizers (gas or electric), make each room an individual unit, complete in itself.

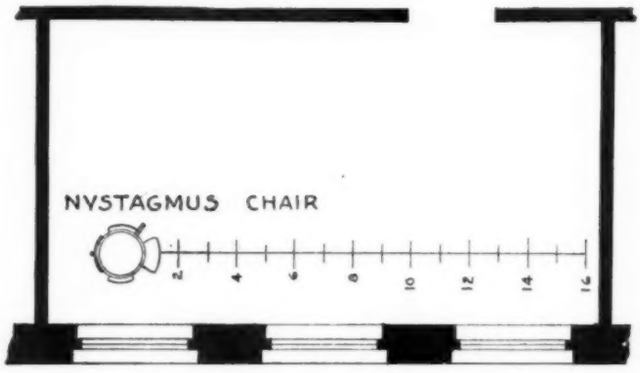
Drinking fountains are provided in all waiting rooms, also separate toilets for men and women. There are separate toilets for staff and nurses on each floor. The children's division has a baby's bath and children's shower. Special toilet, showers and locker rooms are provided on the mezzanine floor for the use of the visiting staff.

Special Electrical Equipment

The building is thoroughly equipped electrically, having, in addition to the ordinary light and power systems, especially adapted systems of wiring for experimental power in laboratories, electrocardiograph distribution for all examination rooms, special attendant signal systems for connection between examination rooms and waiting rooms, complete equipment in electrotherapeutic departments, watchman's clock system, fire alarm, time clocks and complete system for miscellaneous signals, as well as the usual outside telephone



FIRST FLOOR PLAN
SCALE OF FEET



DETAIL OF HEARING ROOM
SIXTH FLOOR
0 5 10
SCALE OF FEET

equipment. Each of the clinic chief's rooms is equipped as a small doctor's office with all the necessary electric devices commonly used by doctors, together with x-ray view box for examining x-ray plates. The laboratories are also completely equipped with electric service, all with a view to flexibility and an opportunity for extensions without impairing the integrity of the systems.

Each laboratory is equipped with high pressure steam, gas, electricity, air pressure and vacuum, the latter two being supplied from an automatic pump and tank in the basement.

In planning this building an attempt was made to give as much privacy to each patient as possible, as self-respecting citizens who are compelled to resort to a hospital clinic are entitled to the same privacy that they would have if treated in a physician's office. This explains the inside corridors and the large number of small examining rooms.

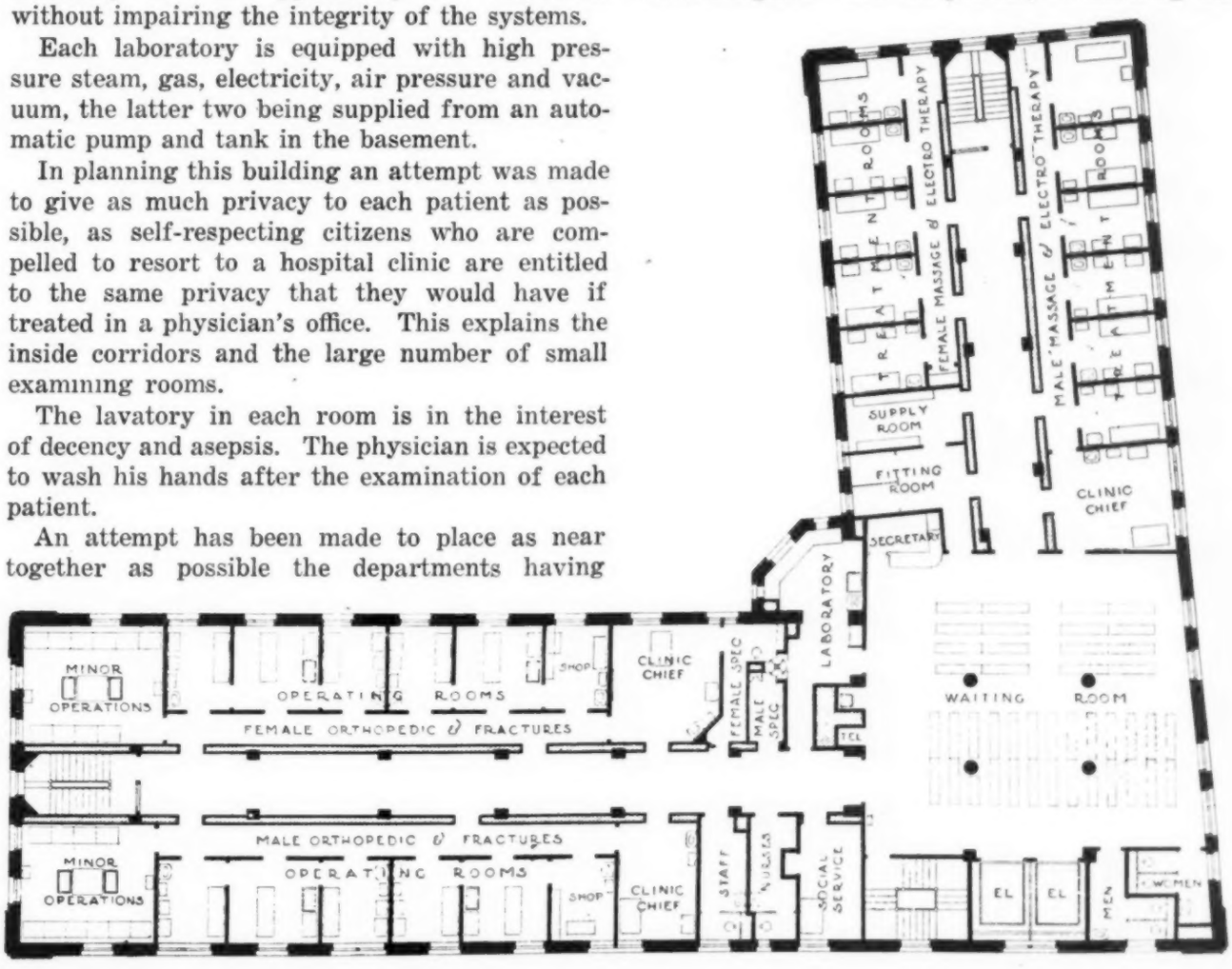
The lavatory in each room is in the interest of decency and asepsis. The physician is expected to wash his hands after the examination of each patient.

An attempt has been made to place as near together as possible the departments having mutual interests, so to speak. The department of physical therapeutics and massage has been placed in one wing of the same floor as the orthopedic and fracture department. The special medical clinics, cardiac, gastro-intestinal, diabetic and nephritic clinics are in one wing on the same floor as the general medical clinics. The eye department and the ear, nose and throat departments are on the fifth floor and the skin, nerve and immunology departments are on the top floor.

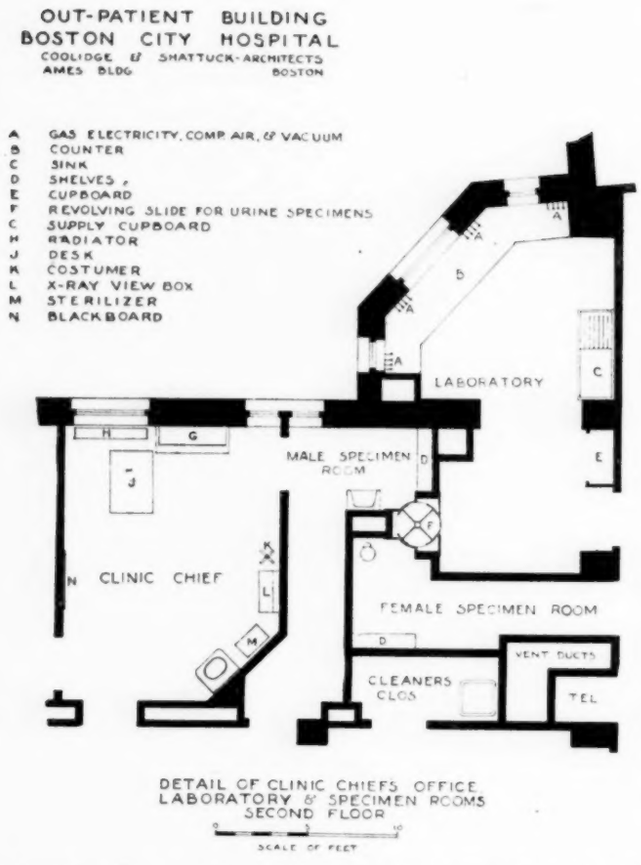
It was deemed wise to place the pediatric department on the first floor, so that in so far as possible the children might be separated as quickly as possible from the large number of patients resorting to this building for treatment.

The male genito-urinary clinic is isolated in one wing, which is reached by a short flight of stairs.

The entrance hall was very carefully planned to avoid, in so far as possible, cross currents. All patients, new and old, must first go to the entrance desk. Old patients show their identification card, which contains their record number, name, address and the clinic to which they have been assigned. The old patient, on showing his



THIRD FLOOR PLAN



identification card, receives a clinic number, then resorts to the department in which he belongs. The clerk takes the number, stamps it on a slip, and places it in the carrier tube that runs to the record room. The record clerk then takes from the files the record in folder with corresponding number, and places it on the carrier, which delivers it to the desk on the floor to which the patient has gone. The new patient, or the patient who has lost his identification card, is referred to the waiting room in the rear of the desk, and in his turn goes to one of the desks shown on the plan. There are three desks instead of two as shown on the plan. One of the clerks typewrites and gives him his identification card and starts his record sheet. The base files are examined to determine whether or not he has been a patient previously. This is done to prevent duplication and in the interest of accurate statistics. At the desk he is also seen by the admitting physician, who assigns him to the proper clinic. He then steps into line in front of the entrance desk and there receives his clinic number.

The children, immediately on entering the pediatric clinic and before taking seats, are seen by a physician, and if he suspects infectious disease he assigns them to an isolation room. If a child is too dirty for examination, he is bathed before being examined. In this department there is a small room marked "Lecture Room" which is used to teach mothers milk modification.

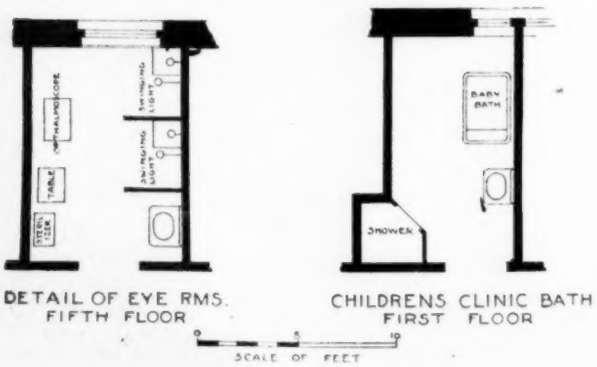
In the genito-urinary clinic patients are seen by the physician in charge and sent in to the specimen room. There they pass a specimen, go through the other door, and appear before the physician's desk once more, when the physician examines the specimen for shreds. They then wait in the second waiting room for treatment. This procedure greatly expedites the examination of specimens. There is a clean, uninfected side of the genito-urinary department with operating rooms where genito-urinary operations are done, and the end room is used for cystoscopic examinations.

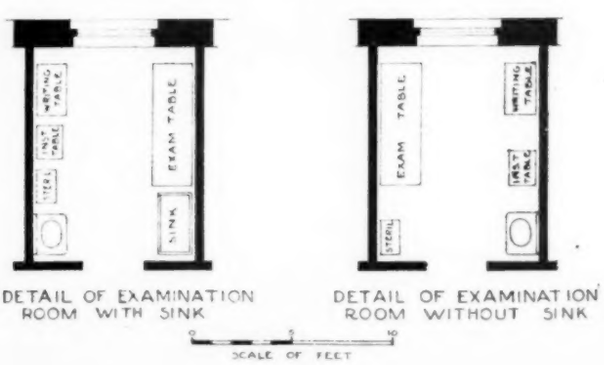
On every floor there is a laboratory for the clinics on that floor. To each of these laboratories is attached a specimen room with revolving drums in the wall between it and the clinic room, so that the specimens can be placed within the drum by someone in the clinic, and revolved where the technician or physician in charge of the laboratory may readily take the specimen out. The pediatric and genito-urinary clinics, because of their location, have separate departmental laboratories. The main laboratory of the hospital has, of course, facilities for tests not within the scope of the laboratories in the out-patient department.

On the surgical floor, male and female, one side is reserved for clean surgery and the other for infected cases.

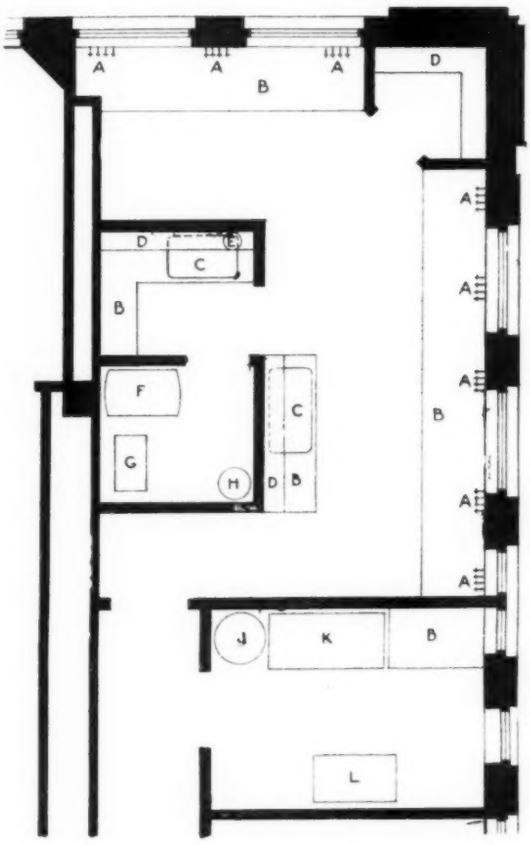
The sinks in the fracture clinic are equipped with plaster traps.

All of the rooms in the special heart clinic are





A GAS, ELECTRICITY, COMPRESSED AIR & VACUUM
B COUNTER
C SINK
D SHELVES
F STILL
F AUTOCLAVE
G GAS OVEN
H STEAM STERILIZER
J CENTRIFUGE
K KELVINATOR
L INCUBATOR



DETAIL OF SERUM LABORATORY
SIXTH FLOOR

SCALE OF FEET

wired to the electrocardiograph in the house, so that electrocardiographs may be taken without duplication of machines.

In the gynecological clinic the two end rooms are assigned to female genito-urinary cases.

In the skin clinic the first rooms on the male and female sides have terrazzo floors and are fitted out as operating rooms for the administration of salvarsan.

The lecture rooms shown on the plans are for the teaching of students.

The out-patient department has throughout a central record system, the records of each patient from every department being filed together. On each floor there is in the southwest corner a clinic secretary's desk, to which all records for that floor are delivered by carrier and returned to the record room after the clinic is closed. The clinic secretary has a messenger who delivers records to the clinic chief. On the wall of each side of the corridor there is a series of drop switches, one for each room on that side. When a room is vacant the nurse on that corridor pulls the drop, which shows on the dial in the clinic chief's office. He then pulls a drop on his desk and lights show in the dial in front of the clinic secretary, who calls the number of patients needed for that particular clinic.

This new building cost $630,000 for its construction. The cost would obviously have been much higher if the land had had to be purchased and if the new building had had to be put up without using any portions of the old. The equipment of the building has cost approximately $70,000.

UNITED HOSPITAL FUND CHOOSES NEW OFFICERS

The United Hospital Fund, which as an association of leading non-municipal hospitals in New York has for forty-six years conducted an annual campaign in their behalf, has just elected Henry J. Fisher president. Mr. Fisher has long been active in hospital work, is president of the Manhattan Eye, Ear and Throat Hospital of New York, and was chairman of the trustee section of the American Hospital Association during 1924. As chairman of the executive committee of the fund from 1918 to 1921, he was in large measure responsible for raising the annual collection of about $200,000 to its high water mark of nearly $1,000,000 in 1919-1920. His assumption of the presidency of the fund is looked upon as earnest that the fund is likely not only to increase the amounts secured from the public for the benefit of its member hospitals, but to broaden its cooperative and informal services to the hospitals and out-patient departments of the metropolis. Frederick D. Greene after fifteen years as general secretary of the fund has retired from professional life, and Minott A. Osborn, formerly secretary of the Yale Alumni Fund, has been appointed to the position of chief executive of the fund, with the title of general director.

Mr. Greene's long service was marked by unusual devotion to his work; he acquired a wide acquaintance among hospital personnel, and attracted especial attention to the fund throughout the country by his statistical reports. During his secretaryship the organization advanced from the status of a "Hospital Saturday and Sunday Association," taking up a collection in the churches and synagogues once a year, to a body active the year round, with the more appropriate title of United Hospital Fund. Fifty-seven hospitals are at present included in the membership. The municipal departments that maintain hospitals while, of course, not participating in the fund financially, are represented in the organizations through ex-officio membership.

Among the fourteen precious objects that Siva and Dhanwantara, the gods of medicine in ancient India, framed by churning the ocean was a skilled physician. Already in 1400 B. C., there existed a system of medicine, the medical caste being named the Vaidya. In addition there were teachers and practitioners who lectured to students and attended the sick. These were called Rishis.

HOW PASADENA PROVIDES FOR ITS CONTACT CHILDREN

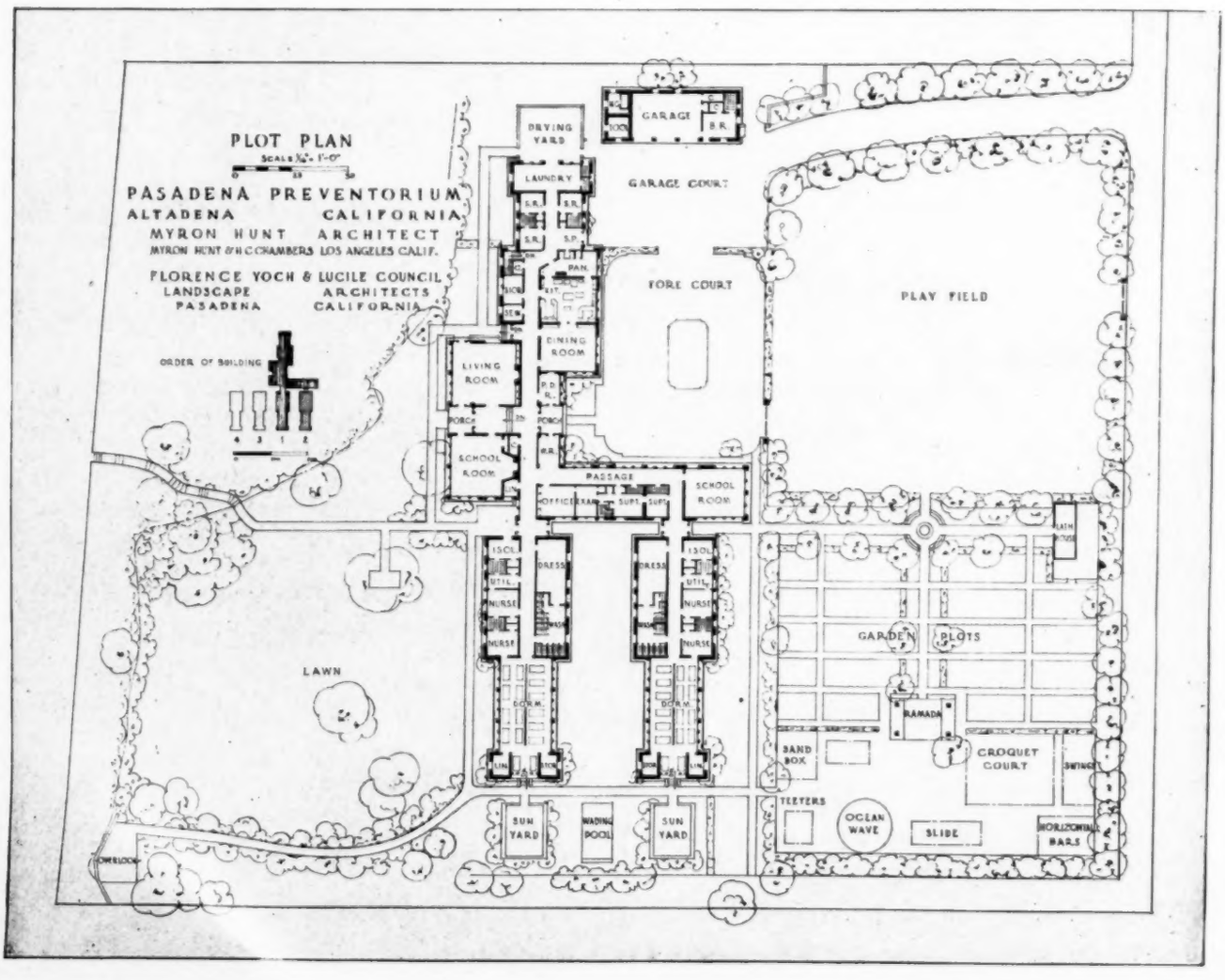
By Myron Hunt, Architect,
Los Angeles, Calif.

THREE years ago the Pasadena Tuberculosis Commitee decided to build a preventorium, or twenty-four fresh air schools, for children under observation in the dispensary of the Pasadena Hospital who come from homes where a member of the family has tuberculosis. In response to the need for housing these "contact children" a building fund was started having as its nucleus the proceeds of the Christmas Seal Sale of 1922 to which has been added the proceeds of the sales of succeeding years, supplemented by other donations.

In the fall of 1923 the site was chosen, a beautiful four-acre tract on the east bank of the Arroyo, near West Mariposa street, overlooking the foothills of the Sierra Madre Mountains. The plans were then drawn for the complete project, the first unit of which was completed in November, 1924. That unit houses eighteen boys all chosen because of their special need for preventive care.

The preventorium is now complete except for one dormitory with its accompanying rooms including a classroom. When the entire plant is completed, including the garage, servants' quarters, gardener's quarters and the improvement of the grounds the cost will approximate $2,000 per patient bed, a reasonable cost considering the small number of patients.

The preventorium is of the Spanish type, having hollow concrete walls and red tile roof. The building is a monolith of concrete. The walls are eighteen inches thick, consisting of a four-inch, outside and a four-inch inside web and a ten-inch



Pasadena Preventorium overlooking the Sierra Madre Mountains.

hollow space with cross webs at the windows and doors and at intervals between where the plane surface exceeds six to seven feet. The construction is carried on by the use of collapsible forms.

This type of thick walled construction, which is being used extensively in the Southwest, produces a building that is warm in winter and cool in summer. The advantages of such a building over the thin walled building are obvious from the therapeutic as well as from the architectural standpoint. The development of this construction in the climate where frost does not have to be considered gives a building fire resistance, except for its roof, at a cost little more than cheap temporary wooden structure.

The building is amply supplied with the conventional school type of window that opens up completely. The floors, except in the laundry where cement is used, are maple. The entire building is substantial and permanent.

As the land slopes about two degrees south it has been possible to keep the building close to the ground by the use of ramps. The grounds are being laid out in orchards and vegetable gardens and grass plots all of which will be kept in good condition by the aid of the sprinkler system that has been installed on the premises.

When funds are available it is planned to have playground equipment in a space set aside for that purpose. A palm-thatched ramada has been erected where basketry and sloyd are taught and a concrete dipping pool has been provided where the children may get water for their tiny gardens. The future plans call for the building of a wading pool.

The details of the interior of the building have all been carefully planned to give a healthful and homelike atmosphere to the preventorium. Inside of the front entrance facing east, is a wide hallway extending through to the west entrance. To the right is the spacious living room overlooking the hills and valley beyond. This, the children's own living room, is attractively furnished with appropriate bright hangings and comfortable chairs and davenports grouped about the wide open fireplace. Under the large windows are seats containing individual toy compartments where each boy may keep his own belongings.

Opposite the living room is the open air classroom which has been equipped by the Pasadena Board of Education, since the school is under the city school system. In addition to the usual studies the children are taught basketry, sloyd and

The children's dining room made attractive by bright colored furniture and hangings.

The out-door ward where the fifteen little boys sleep in the fresh air and regulated ventilation.

gardening. Each boy has his own garden plot where he may raise flowers or vegetables.

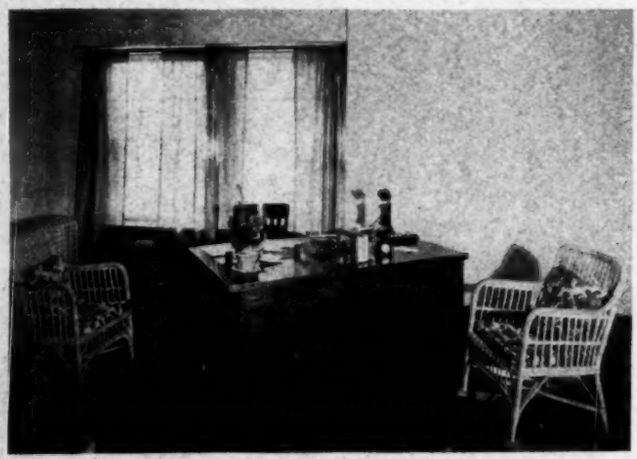
Down the corridor from the classroom are the administration offices, examining and reception room, linen and utility rooms. The nurses' living and bedrooms are also at this end of the corridor. In addition there is an isolation room done in blue and yellow, where the newly admitted child or one requiring isolation may be kept for a short time.

A corner of the children's living room. The window seats have compartments for toys.

Across the hall are the dressing rooms with individual steel lockers and bathrooms with showers and individual cubicles for toilet articles and any other personal effects.

The dormitory, or sleeping porch, is open to the east, west and south so that the maximum of sunshine is afforded. As a protection against the heavy winds of this region, an especial hinged window has been provided. If one happens to visit the preventorium from one to three o'clock any afternoon he sees the eighteen boys tucked in bed or quietly reading on their honor, as this is the rest hour. Outside the dormitory is a walled-in sun porch where heliotherapy treatments are given.

The north end of the building houses the service department. The dining room is especially bright and cheery with its apple green chairs and tables and yellow hangings. The dishes are also gayly decorated in designs that appeal to children.



The nurses' office.

The children admitted to the preventorium range from five to twelve years of age. Entrance is not limited to Pasadena children who are, however, given preference. The dispensary service acts as a clearing house for the school, as examinations are given in the clinic every Friday morning and children are chosen from these examinations.

A sliding scale of payment is maintained varying from the entirely free case to the forty-five dollars a month child. In the short time that the preventorium has been running it has not been possible to estimate the accurate per capita cost. The patrons or guardians are asked to pay the cost of maintenance, if possible, or at least a part of it according to their ability to pay. The deficit in running expenses is being met by the Community Chest of Pasadena. All equipment and furniture have been donated by various patrons, clubs and organizations.

The medical staff consists of an examining physician at the dispensary, and specialists in eye, ear, nose and throat, orthopedics and pediatrics, all of whom give generously of their time and skill. In addition a prominent orthodontist of Pasadena offers his services to correct defects and malformation of the dental arches. All dental reparative work is done in the dispensary clinic.

INVESTING ENDOWMENTS OR TRUST FUNDS*

By Charles R. Holden, Vice President, Union Trust Company, and F. H. Rawson, Former Chairman, Board of Trustees, Presbyterian Hospital
Chicago

THE BASIS of real estate values to be acquired and kept up to date by persistent and patient observation of every transaction is of two general classifications.

In every city or community there are certain standards of value used by real estate dealers to aid in fixing valuations. Figures of values assessed for taxation may be available. The standard may be found in local publications giving basic valuations. In some cases a basis of valuation must be computed from the facts shown in recent transactions. In all cases the actual present value must be computed by adding or subtracting from the appraised or published general valuations such percentage as local experience has agreed upon as the variance between such published values and the general average of current values. In nearly every locality, and especially where real estate dealers are well organized, there will be generally accepted rules for considering how much more valuable a corner lot is in comparison with an adjoining lot a certain distance from the corner, and how the valuation per square foot depends on the depth of the lot.

Such values must always be reduced to the test of what property actually sells for, not the price some one may think it might be worth.

After familiarizing himself with the current methods and basis of computation of the general values in a specified locality or class of property, the valuer must next fully consider all elements bearing on the value of the particular portion in question.

It is gross carelessness to make a loan on property without actually looking it over carefully and noting its surroundings. Schools, institutions, objectionable businesses located nearby, unsuitable neighboring improvements, poor transportation facilities, all may materially affect the specific value. The fitness of the building for the locality as it exists, what danger there may be of its future standard of use being greatly lowered by unsuitable development of vacant property near it, and especially any observable tendency toward a change in the character, in color or in race of the local population, are all elements to be considered.

Next after fixing a ground valuation, the value of the building should be determined. This should be first computed on a standard basis. It will usually be found that the custom among experienced real estate men in the locality is to base such computation on a cubic foot valuation. For apartments, a valuation of so much a cubic foot is estimated; for a store building a different value per cubic foot is used.

The result so reached may be made up on two different estimates of cubic foot values. One may take first a prejudged standard value of what the building of such size and character should be worth. Then one may take the standard of what the cost of such a building should be. If then in existence a depreciation factor for age would be given consideration.

Finally, the more or less arbitrary valuation thus computed should be compared with two other valuations duly formulated. The most important of these is the sale, or cash market, value based on recent transactions. The other is consideration of the actual cost, if the building is of comparatively recent construction, or is in the

The Real Estate Bond or Loan

BEFORE investing in real estate bonds or loans it is essential that trustees have a clear knowledge of real estate values. Standards of value used by real estate men can be determined by recent local transactions or be found in publications in the community.

After the board has become familiar with general values the ground valuation as well as that of the building should be determined. The less arbitrary value thus computed should be compared with the sale, or cash value, based on the recent transactions and the actual cost of the building. The cost, or value, of producing the property and by the income received from it. Practical methods of procedure in arriving at these values are fully explained by the authors.

*This is the second of the series of two articles on the investing of trust funds. The first article appeared in our October number, page 302-304.

process of construction at the time of consideration.

In every case it must be remembered that a sound credit can rest only on an actual practical sale, or liquidation value. Rental or operation values are rarely the same as sales or liquidation values.

Rather by way of illustration than to give exact figures, the detail of such method will be analyzed. As figures on building cost vary from time to time and in different localities, and these are current Chicago figures, the following figures should not be used without verification and checking, even in Chicago.

Two Ways to Compute Value

There are two ways to compute the value of a property. The first is by computing the cost of producing the property. The other is by the income received from the property. The average new apartment building costs about thirty-five cents a cubic foot to build and finance. Multiply the length by the width by the height from the cement floor in the basement to the roof line of the building to obtain the cubic contents. Then multiply by thirty-five cents a cubic foot to obtain the average cost of a good apartment or store and apartment building. To this amount add the value of the land, computed as stated above. The sum of the two amounts will give the total value of that piece of real estate.

Since this is the value of the property under consideration, it is necessary to consider the element of the income from rents on such property sufficient to give the owner a fair income on such valuation as has been computed.

To make a calculation as to income, proceed as follows:

Compute the total fair rents obtainable from renting the property for one year. This amount should represent sixteen and two-thirds per cent of the total value of the property. An easy way to figure is to multiply the yearly rental by six and the result will be the total value of the property. Another easy and quick way of figuring the average apartment building is by finding the total number of rentable rooms, not counting bathrooms, reception halls and rooms in the basement. Multiply this number by $1,300 a room and the result is a figure near the value of the cost of the building. To this is to be added the value of the land arrived at, as has been explained before.

If the total loan on the same exceeds sixty-five per cent of that amount, a big chance is taken in purchasing the bond. There are better investments to be had in the market. The cost a cubic foot is subject to change, should the building face one of our best boulevards, thereby requiring costlier fronts and more expensive fixtures, but the rental income ratio remains the same. If the building is a modern hotel, built on piles or floating foundation, the cost of construction of such a building is sixty to seventy cents a cubic foot according to present values. If the building is on caissons to bed rock the cost is seventy-five to ninety cents a cubic foot. To this cost also the price of land is to be added.

The average mill constructed brick factory building costs twenty cents a cubic foot. If the same building is of reinforced concrete, the cost is approximately thirty-two cents a cubic foot. The average modern two apartment building, twenty-four feet wide costs about $250 a running foot. A building sixty feet deep would cost $15,000. The ordinary good brick bungalow, twenty-four feet wide costs $160 a running foot from the front to the rear end. These figures are all based on present day construction in Chicago. When the value of an older building is computed, one should use today's figures, deducting therefrom three per cent a year depreciation according to the age of the building.

An important class of loan on real estate that stands by itself is real estate loans on farms. These loans should only be made in the first instance by or through an experienced organization adequately equipped to apply the following general rules.

Inspection on Every Loan

Inspection should be made on every loan, with due inquiry as to the productive character of that particular farm, the condition and adequacy of its improvements, transportation facilities, ability and character of the farmer. Due limitation of such a loan to not over the loaning value an acre in the general locality, due limitation of consideration to any extent of value of improvements, and the crops the farm produces, must be clearly designated. This requires rather intimate knowledge of the practice of lenders as to the locality concerned. If possible, an efficient organization for collection of interest should also be back of the loan. Otherwise the details as to insurance, preparation of papers and other matters are quite the same as in city real estate loans.

While there are fluctuations, usually in cycles of eight to ten years in the demand for real estate loans and the interest return safely to be secured, there is in the market for them a more uniformly sustained trade than in other securities. As already intimated, the investment field may and should consider doing business in other bonds and securities.

NOTES ON

ADMINISTRATIVE PROCEDURES

MANAGING THE STOREROOM

Two major factors enter into the operation of every hospital storeroom. These two fundamental policies in combination, form the basis for a system of storeroom operation that is an assurance against gross inefficiency.

The first of these fundamental policies calls for the grouping of the storeroom activities and records with those of the purchasing department. As Chapman, in *Hospital Organization and Operation*, says: "One's first reaction to this grouping of institutional activity may be that it is not logical and that both the purchasing department and the storeroom should be definite entities. However, their work is so closely interrelated, and the potentialities for good emanating from their cooperation so great, as to demand a most intensive combined supervision by the administrative officer. In an organization without an assistant superintendent this department should be very closely watched by the superintendent. However, in the event that there is an assistant, to him should be delegated as a primary duty the department of purchase and issuance."

The soundness of this opinion is being appreciated more fully by an ever increasing number of hospital superintendents. Its inherent truth is being proved by everyday practice.

The second fundamental policy lies in the direction of stock control. Since it is only human nature to consider one's own wants and since judgment is warped by personal desire, it is easy for some department heads to supply themselves with an excess of material or with goods not entirely necessary to the operation of their department. For this reason, it is imperative that the superintendent sign all requisitions and that he retain the right to reject or alter any requisition made against stored material, which he deems excessive or unnecessary. Revision or alteration of requisitions should be an established administrative prerogative, since few phases of hospital operation possess greater possibility for economy than the control of issuance. In substantiation of this claim, quotation is made from Dr. A. C. Bachmeyer, in his article on the "Control of Hospital Supplies and Equipment," in THE MODERN HOSPITAL Year Book, 5th edition:

"The control of all material and supplies issued from storerooms is strictly and solely an administrative function, and therefore the disbursement of all supplies from the storerooms should be made only upon authorized written requisitions . . . It is the author's conviction that the responsibility for the procurement of all hospital supplies and materials should be vested in one individual, rather than that it be divided between various department heads or other officials. As a general rule, there is greater economy without loss of efficiency if the ultimate consumer is not directly concerned with, or responsible for, purchasing, although it is, of course, proper and necessary that every department head be consulted about the quality, and that his or her advice and suggestions be considered in the establishment of all standard specifications regarding materials, supplies or equipment."

Classifying Hospital Supplies

That a systematic and efficient method for storage and issuance might be carried forward with the least expenditure in effort, and that purchasing and accounting procedures might be greatly simplified, all hospital supplies should be classified and divided into logical groups. This classification depends somewhat upon the character of the institution. A maternity hospital would probably have a classification somewhat different from that of a tuberculosis sanatorium or an institution restricted to children. In principle, however, the classifications would be the same. A list of divisions in a general hospital follows:

Account Number	Division	Numbers Assigned
1	Administrative supplies ...	1— 999
2	Housekeeping supplies	1,000—1,499
3	Laundry supplies	1,500—1,599
4	Clothing and bedding supplies	1,600—1,699
5	Clothing and bedding.....	1,700—1,999
6	Maintenance and repairs...	2,000—2,199
7	Dietary supplies	2,200—2,999
8	Food stuffs	3,000—3,299
9	Medical stationery	3,300—3,399
10	Surgical instruments	3,400—3,999
11	Medical and surgical	4,000—5,999
12	Anesthesia	6,000—6,099
13	X-ray supplies	6,100—6,199
14	Laboratory	6,200—6,299
15	Nursing supplies	6,300—6,399
16	Uniforms and text-books ..	6,400—6,499
17	Training school	6,500—6,599
18	O. P. D. administrative supplies	6,600—6,699
19	O. P. D. social service....	6,700—6,799
20	O. P. D. M. & S. supplies.	6,800—6,899
21	O. P. D. day drugs	7,000—7,199
22	O. P. D. orthopedic	7,200—7,299
23	O. P. D. dental	7,300—7,399
24	O. P. D. eye	7,400—7,499
25	O. P. D. night clinic	7,500—7,599
26	O. P. D. prenatal	7,600—7,699
27	O. P. D. layette supplies..	7,700—7,799

It will be noted that drugs are not included in this classification. This elimination is made because few hospitals find it satisfactory to combine the general storeroom with the drug store. Usually the general storekeeper is unschooled in medicine or drugs. This lack of training unfits him to handle drug supplies with any degree of efficiency. It is the common practice, therefore, to segregate the drugs from the general supplies and to maintain a separate drug storeroom near the medical wards.

Assigning a number for every article and a series of numbers to each division permits the storekeeper to maintain his storage system, stock book, perpetual inventory, and all records on a numerical system. The simplicity of this, over any alphabetical or nomenclature system, is apparent. Every division carries an excess of numbers that provide against the introduction of new articles from time to time and the necessity of changing an entire series of numbers or amplifying an established system.

Occasionally it becomes necessary to return merchandise, either because of poor quality or possible deviation from specifications. In such an event, accurate records should be made of the transaction in order that the institution may receive proper credit, or that duplicate payment may be avoided upon replacements. In some institutions this occurrence is frequent enough to justify a special form. When used, this form should be made in duplicate, the carbon being retained by the storekeeper for his permanent record, the original being sent to the purchasing department that will hold it until the transaction is completed. After that it will be sent to the accounting department for proper entry.

Keep Supplies Under Lock and Key

Comparatively few hospitals still maintain open storerooms. The majority have learned from the sad experience of the few that have encountered both petty and major thievery. The hospital storeroom houses a multitude of goods, some of which make a strong appeal to the light-fingered. Supplies, in every instance, should be kept under lock and key, and no one allowed in the storeroom except accredited members of the personnel—and then only in the presence of the storekeeper. The responsibilities and obligations devolving upon the work of storekeeping should be firmly impressed upon the person in charge, who should be made to understand that under no circumstances are any articles to be taken from the storeroom except upon properly authorized written requisitions.

This does not mean that emergencies cannot be met or that certain deviations from established rules cannot or should not be made. However, rules and regulations are of little value, if not strictly enforced, and since emergencies are bound to rise, from time to time, there should be rules governing them, and every effort should be made to follow such regulations. When this is conscientiously done "emergency" requisitions will be greatly reduced.

In the majority of hospitals one day of each week is set aside as "requisition day" for all departments, except, perhaps, the dietary that requisitions materials daily. Ordinarily, there is little need for interrupting the activity of the various departments or disturbing the even tenor of the storeroom by issuing requisitions on days other than the established weekly supply day. This is a regulation that will in itself minimize the number of emergency calls made upon the storekeeper.

Furthermore, this policy has a tendency to assist in the control of supplies, in keeping perpetual inventories, in conserving material on hand, and in preventing discrepancies that occur between amounts received and those issued, since it provides the storekeeper with two or three days in which to issue material and the following days of the week for record and perpetual inventory adjustment.

According to the best authorities in the field, the following policies will be found acceptable to nearly all hospitals:

Purchase on a sound, practical basis.

Receive in an orderly, businesslike manner.

Control both receipt and issuance by proper records.

Maintain established days for issuance.

Establish units of issuance so that small quantities may be supplied regularly and often, rather than large quantities infrequently.

The administration of the storeroom should in no way be hampered by "red tape" or administered in a niggardly fashion. Since the storeroom can easily become a source of loss, any continued wastefulness should be considered sufficient cause for discipline.

EFFECTS GAINED THROUGH COLOR

The effect of touches of color in stimulating the appetite is illustrated by a hospital in Minnesota in the practice of having a bowl of fruit on patients' trays each noon and evening. This bowl contains several different kinds of colorful fruits that the physician in charge recommends for the patient. The superintendent of the hospital says that this food service feature adds much to the patients' happiness and does much to educate those who are ill to the dietetic value of good fresh fruits.

HOW DO YOU IDENTIFY THE NEW BORN?

Since the ancient and decidedly ethereal belief still persists that the identity of the new-born baby is occasionally lost by hospital personnel and that a mother is sometimes given the wrong baby, it behooves all hospitals to fortify themselves against the growth or continuance of this popular fallacy.

The persistence of this idea seems foolish, for strict adherence to any of the several methods of identification is a safeguard against mixing. It must not be forgotten, however, that if once firmly entrenched in the public mind, any idea, no matter how imaginative, is hard to correct or erase. Furthermore some expectant mothers are susceptible to morbid inhibitions and are apt to believe rumors of improbable happenings.

For these reasons, it is essential that every maternity department employ one of the rigid identification methods, in order to assure every inquirer that interchange is impossible. A courteous and convincing explanation of any system will do much to free all minds from the needless fear of being given the wrong child.

Necklace Method Widely Used

Perhaps the most universally employed method of identification is the necklace of beads with which the baby is invested immediately after birth. These beads are assembled in the delivery room to form the name of the baby, namely, "Helen Smith." A tag with the name of the baby and the mother is also attached to the basinette. Under this system there is no difficulty in retaining a baby's proper identity and very seldom is there any element of doubt in the parent's mind.

A pamphlet, serving as a record of the baby's birth, giving the date, hour, weight, height, and carrying the signature of the attending physician, is presented to all mothers in one hospital. It also contains a well worded paragraph or two on hospital ideals and services.

Another form of necklace identification is the band of tape on which is hung an aluminum disc bearing the name of the mother and the ward or room number. In all cases, care is taken to tie the necklace loosely enough so as not to chafe the neck.

Many hospitals employ the foot and finger print method of identification. When practiced with care, this method is perhaps the most positive of all means, since the construction of the skin never changes. However, many nurses object to the method on the grounds that it is "messy" and unless extreme care is taken the print will be little more than a smear of indelible ink. Ordinarily this system is used in conjunction with a second means, such as the necklace or bracelet. It must be said, however, that mothers usually prize the footprints of their babies.

One northwestern hospital employs the identifying adhesive plaster. Before the new born leaves the delivery room an adhesive plaster containing the name is put on the baby's back; then as soon as the baby is given a bath in the nursery this adhesive plaster is substituted for another bearing the name, time of birth, the name of the attending physician and the register number.

Several Systems in One Hospital

Several hospitals employ more than one system of identification. One Chicago institution uses three methods. Two tapes with duplicate numbers are sterilized in each labor drum and before the cord is cut one of these tapes is tied to the mother's wrist, and one on the baby's. As soon as the cord is cut and before the baby is removed from the confinement bed, an adhesive tag is put on its back. Neither the tag nor the tape is removed while the baby is in the hospital; it is sent home wearing them. Footprints of the baby are made before it leaves the birth room. One copy is made on the record sheet, and a second copy is sent to the mother.

A hospital in Washington, D. C., also employs three means for identification. Here the baby is furnished with an adhesive bracelet at the time it receives its first bath. This bracelet bears the name and number of room or bed that the mother occupies. In addition, every bed in the obstetrical service has a bassinette corresponding in name and number in the nursery. Furthermore, a footprint is taken of the baby some time within the first twenty-four hours, the prints being placed on the back of the delivery record, kept in the hospital files, and the birth certificate that is supplied the mother.

Birth certificates have been found, by a great many hospitals, to be a builder of good will and a point of keen interest between the mother and the institution.

THE ADMITTING OFFICER AND PUBLICITY CONTACTS

Because it realizes that the desk of the admitting officer is one of the three important contacts which a hospital has with the public, (the others being the telephone and the information desk), Johns Hopkins Hospital, Baltimore, Md., has appointed a trained social worker in that position. The principal qualifications for an admitting officer are executive ability and understanding of people, and of economic and social conditions; tact, some medical knowledge, and the ability to know when to be insistent and when to yield. The admitting office is a business office, and the person in charge is a part of the administration staff.—*Better Times.*

The MODERN HOSPITAL

The Modern Hospital Publishing Co., Inc.

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22 East Ontario Street Chicago, Ill.

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MORALE IN THE HOSPITAL

MOST observers will agree that the present period sets a store by fostering the community spirit, far beyond what we met twenty years ago. This is true whether in the conduct of great industries, or specialized and self-contained institutions. Much of this emphasis is a heritage of the war, much the outcome of the practical application of the principles of group psychology, and all of it centers on the endeavor to induce the human agent to put into his daily work that spirit of zest and ordinary honesty that makes the commonweal the goal of the general effort.

It is a rather sad, if justifiable, comment of our time that—while there is no service that demands more solidarity of purpose, no service where cordial cooperation is more absolutely the price of success—it is true that many modern hospitals, great and small, are significantly without the spirit in the personnel that is connoted by the expression "team work," the spirit which diffuses itself from the front door to the charity ward, and the absence of which is manifest all down the line between these extremes.

Hospital executives of tried quality will agree that the men at the top are the primary sources, whence morale is to proceed, and it is to the education of these agents that effort should be first directed to the end of that cultivation of the spirit of service which is essential to the maximum good.

We think that most of the justifiable criticism that comes to the hospital of today could be forestalled were the necessary time and appropriate methods used to implant the idea in the minds of hospital personnel that the institution *belongs* in greater or lesser degree to every one who works within it. An ideal state of operation is easy of delineation and the attainment of that state is readily shown, as lodged in the performance of each unit of personnel that makes up the complex. The chiefs of professional service and the ward orderly are alike receptive to the pat on the back which goes with telling them that they are real cogs in the machine. Those who do not respond and who will not perform, and whose sense of loyalty to the institution is always secondary to individual bents and prejudices, lower the general stamina, while they are dissipating their own; this defection finds expression in no quarter more frequently than in the "intelligentsia" that makes up the medical and nursing staffs. Wholesale purgation of such people, without regard to rank, and the doctrine that the hospital is bigger than any individual

is a holy and wholesome thought for diffusion.

We have in mind a story told of one of our greatest railway executives who began his career in the machine shops of the road of which he is today the head and front. While this man is the most exacting critic of his subordinates, he is *pari passu* the outstanding composer of labor disputes in the railway world of America. It is said that on any visit to the shop where he began his career he is greeted on all sides with "Hello, Wallace," and on one of his inspections he directed that an old employee be laid off for ten days because of manifest laxity. The victim's comment came: "Well, it's all right, if he did it, for he's always just." The hospital executive who gets such a concept through his institution will literally shed morale all down the corridors, but we doubt if there can be anything but futility, without some measurable fund of the qualities that beget such loyalty and dependence.

In civil and military organizations alike, the ultimate result rests most on the make-up of the "old man"—loved and feared and who in point of years may be the merest stripling and yet worthily and affectionately held to be the "old man." One of this country's distinguished hospital executives is known in his walk of life as the "General" and in the military world he would be just that.

After all, morale is a quality that radiates, and the surface from which most of it emanates is at the top, where example enforces precept.

PHYSICAL EXAMINATIONS FOR EMPLOYEES

In ancient Greece, no person was allowed to serve in the temples of Æsculapius unless he was in sound physical and mental health. This policy grew from a variety of sources, chief among which was the knowledge that a subnormal person is the poorest kind of an advertisement for a hospital and at the same time is apt to be rendered at least partially inefficient by reason of his ailment or disease. Modern hospital workers realize that the matter goes even deeper than this and that such persons, especially if they be employed in the dietetic department, may be actually the spreaders of disease.

The superintendent of a 450-bed hospital has recently written us that he has conducted a survey of his employees. It was found by him that at least fifty per cent of these were employed from the wards. In connection with this survey he also tabulated the amount of sick leave which these employees had had and the amount of medical and surgical assistance that had been given them by the hospital. He found to his amazement that he had a number of syphilitics, diabetics and tuberculous on his payroll. Also that a number employed in heavy duty work were suffering from hernias, hemorrhoids and similar conditions, persons who had remediable defects, but who had not reported them for fear that they would be required to undergo an operation.

The situation thus created, presented two different angles. First, what was to be done with those sub-normal employees already on force? Second, what was to be done as a prophylactic against such conditions in the future? The second problem was attacked first and it was required that no person be employed in any position until he had successfully passed a thorough physical examination. As the result of the examination of a considerable number of applicants for employment, it was discovered that at least seventy-five per cent of these were suffering from one or more defects or diseases which would make the applicant an unsatisfactory industrial risk. So high was the percentage that the superintendent whom we are quoting is of the opinion that it was higher than the percentage that would be encountered in those desiring employment in other industries.

The first phase of the problem was a great deal more difficult to handle. It was decided to treat free of charge those employees who had remediable conditions and one by one the members of this group were admitted to the hospital and given suitable treatment and returned to their occupation. There remained, however, a residuum of employees, who, on account of long and faithful service, it was desired to retain in employment as long as possible. For example, there was a gardener who had been employed by the hospital for nearly twenty-five years. He was found to be suffering from diabetes and tuberculosis. To discharge him meant hastening his death because he had only a small store of savings and was without relatives or family. It was therefore the obvious duty of the hospital to care for him as long as he lived. He was accordingly admitted to the tuberculosis ward and treated for the two diseases from which he was suffering. Quite unexpectedly, this employee gained very rapidly and after a few months of hospitalization was given some light duties to perform about the wards. Each one of the old employees was treated as a separate and distinct case.

The result of this work not only improved very materially the physical condition and, therefore, the efficiency of the entire personnel of the hospital, but also had the effect of raising the morale. New employees who successfully passed the

physical examination felt that they had accomplished a great achievement. It is a curious thing, but human psychology is such that if one should put a fence about a place and make it difficult to get into it, everybody is anxious to gain admission, and having done so, is very anxious to remain. It is believed that not enough hospitals are paying close attention to the physical condition of their employees. Certainly they are not conducting periodic health surveys as do many other industries. The maintenance of health among hospital employees is a question meriting the careful consideration of hospital administrators.

TALKING IT OVER

THE Louisville conference is now history. It was a great success as hospital meetings go, and it was so because more than at any previous convention of hospital people the spirit of "Talking it Over" was in the air. The round table idea always makes a strong appeal and throughout the week it was apparent that a wider range of subjects of real importance commanded the interest of informal groups.

* * *

THE spirit of these meetings, while an intangible element, is the quality that makes those who travel far feel rewarded for the effort, and the spirit at Louisville was all that anyone could desire. The columnist congratulates the officers and the members of the association on the twenty-seventh annual meeting fostered by the A.H.A. In a curtain call the star of "The Auctioneer" said that no matter how good the play or how well each actor did his or her part, the result would fall short of success if the audience did not have a willing spirit of harmony. So, too, with hospital meetings. Those who come from far and near should bring a crystallized interest in current subjects of moment, and each must contribute his part toward the success in order to become the greater beneficiary.

* * *

THE outstanding impression resulting from the Louisville meeting is that big things are ahead for the American Hospital Association. The combined influence of the institutions represented at the conference, if properly directed during the coming years, will not only greatly improve present standards of service, but will make our hospitals vastly more helpful in all community health work.

* * *

THE hospital world is fortunate in having a Bachmeyer at the helm of the association during the coming year of transition and new responsibilities. His wise and deliberate judgment encompassing a sound knowledge of medicine, hospital administration, public health and professional education will have an opportunity to manifest itself through a quality of leadership of which our field stands in greater need today than ever before.

* * *

ALSO it gives all of us a feeling of security that Dr. R. G. ("Dickie") Brodrick, as president-elect, will take up the responsibilities of the association when Dr. Bachmeyer's term is completed a year hence. Here again is a man qualified to lead and direct hospital thought during the period of adjustment and enlarging opportunities. A retired medical officer of the Navy and a veteran of the Battle of Manila Bay; a health officer who served with distinction in the dark days following the San Francisco disaster; the builder of the San Francisco General Hospital; and still more important, the creator of the Alameda County Hospital plan described elsewhere in this number, Dr. Brodrick can contribute much inspiration to the upbuilding of this field and to the orientation of hospital people in relation to the broader aspects of community health service.

* * *

THE dramatic incident of the Louisville meeting was the plan of the trustees to purchase a permanent home for the association—a plan enthusiastically approved by the membership, from which already there has been gratifying response toward financing the project through the purchase of second mortgage bonds.

* * *

FOR the past five and one-half years the association has been housed in temporary quarters at the present location, where there is no possibility of expansion and insufficient space even for the personnel needed to carry on the routine work. The plans for acquiring the new home were presented by that wise counsellor, Senior Trustee Borden, whose personal endorsement of the project was sufficient assurance for the membership.

* * *

THE intellectual treat of convention week was the oration of Dr. Edward R. Palmer, of Louisville, delivered at the annual banquet on Tuesday evening. The subject—"The Doctor—Past, Present and Future"—was so appropriate to the occasion, the trend of sustained thought so lofty, the words of the orator chosen with such delicate appreciation of their shades of meaning, and the discussion of the theme so constructive that the message was delightfully reminiscent of Sir William Osler and his addresses which contributed so notably to the distinction of medicine as an art and a science. Witness these excerpts from Dr. Palmer's peroration: "To the evolutionary medical philosopher the outlook for humanity is essentially optimistic. His faith in the correctness of the principles underlying the practice of medicine is strong, and his belief in man's higher destiny, both here and hereafter, is unshakable. . . . The span of life will be immeasurably prolonged and death the result of natural wear and tear at a ripe old age. Then will humanity have reached that Utopian stage of universal democracy of a universally healthy and happy people, whose most respected members will be the broad-minded, highly trained family counsellor and conservator of health—the doctor of the future." This dinner should not be mentioned, however, without paying tribute to the grace and charm with which President Gilmore presided throughout the evening.

* * *

THE mention here of Sir William Osler brings up the subject of his biography by Harvey Cushing, published a few months ago. The life of a great physician written by a great surgeon, and the life of each so closely related to hospital development, means that this book cannot but find an abiding place in the personal libraries of hospital workers. Biography has been described as "the art of writing trifles with dignity" and in these two volumes the author shows us that in literature as in surgery it is the perfection and coordination of trifles that achieves that excellence the world calls genius.

A QUESTION much discussed at several of the recent hospital meetings was how we may best deal with the cults which are insisting on recognition, and through political channels are forcing their pretenses on hospital boards in some of the states. That astute author, journalist and literary critic, Henry L. Mencken, recently volunteered a layman's diagnosis that may be helpful to some of us who are too close to professional work to understand the psychology of "homo boobiens" whose patronage makes quackery flourish. He says: "As everyone knows, scientific medicine has made more progress since the middle of the last century than it had made in the fifty centuries preceding. Today it is rapidly divesting itself of what remains of its old superstitions; it is becoming scientific in the exact sense, and year by year its practical efficacy, its capacity to cure disease, is greater. Yet in this very time of its greatest progress is it confronted by ever-increasing hordes of quacks. The very day that news of insulin is in the newspapers, *homo boobiens* seeks treatment for his diabetes from a chiropractor. Why? The reason seems to me to be simple. When an ignorant man goes to a doctor, he wants not only treatment, but also enlightment and consolation. He wants to know what is the matter with him and how it is to be cured. Now try to imagine a medical man explaining to him the nature of diabetes and the action of insulin. If you can imagine it, then you have an imagination indeed. The whole thing is inordinately complex. The explanation must be itself explained. To get to the bottom of it, to understand it in any true sense, is a sheer impossibility to a man not especially trained, and that training may be given only to men of unusual intelligence. But any moron can understand the explanation of a chiropractor. It is idiotic, but like most things that are idiotic, it is also beautifully simple. So the moron grasps it—and cherishes it."

* * *

THE trustees and other friends of our hospitals so seldom come in contact with comments other than complaints made by patients that Dr. Munger's method of meeting this situation is of interest to all of us. He says: "I started a cross reference section in my letter files, entitled 'Compliments from Patrons.' The rapid growth of this file was surprising even to me, particularly so as it included only those kind expressions that the satisfied person had taken the trouble to put into letters. In order to bring them to the attention of the trustees, at first they were read at the meetings held each month and then were left on the chairman's table where they were always scrutinized further by the various trustees."

* * *

"A TELEPHONE in a patient's room is not an unmixed blessing" according to a prominent hospital superintendent-consultant, who writes: "When our private pavilion was being erected opinion was divided as to the desirability of direct telephone connection with the patients' rooms. After going into the matter carefully with the members of the visiting staff, it was finally decided that the interests of the patients demanded the exclusion of any such system. In some instances a direct telephone connection would undoubtedly be a source of comfort to the patients, but it was the feeling of the majority of us that the system was liable to abuse, that patients would frequently be disturbed when they ought not to be, that convalescents would be tempted to converse interminably, that it would not be possible to keep closed the doors of the rooms in which such conversations were going on (especially in summer) and that acutely sick patients would be annoyed by the conversation of their convalescing neighbors who might not be considerate of the others."

* * *

THOSE who have to wade through hospital reports are sometimes rewarded with thoughts and suggestions of human interest, rather than with only statistical details. Dr. D. A. Powell, superintendent of the North Wales Sanatorium, Llangwygan, Wales, in the thirteenth annual report of the King Edward VII Welsh National Memorial Association, presents several items of interest to others besides tuberculosis sanatorium workers: "Observation cases constitute the salt of institution life; they present the most interesting problems of differential diagnosis, both on the medical and surgical side. Cases of this kind fulfill a most important and salutary function."

* * *

HIS paragraph on the care of hospital grounds is interesting as well: "The grounds surrounding the institution are rapidly improving and reflect great credit upon the whole of the garden staff, among whom I include the graders. 'A garden is a luvsome thing, God wot,' but in a sanatorium, a beautiful garden has far more than an esthetic effect; it is an essential part of our armametarium. It acts directly by serving as a medium for treatment by graduated labor, and indirectly by its appeal to those powerful, but subtle agencies that do so much by enlivening the imagination, soothing the mind, and comforting the spirit, to foster the will to live and to fortify our sense of well-being, thus rendering powerful aid to the healing forces of Nature. In these days of therapeutic materialism, of the syringe and the scalpel, we guard against the vulgar error of studying the morbid process to the exclusion of the personality behind it; of treating disease and ignoring the patient."

* * *

FURTHER along in this report Doctor Powell discusses the necessity for after-care work, and this is amusingly illustrated by the following incident: "A patient suffering from spinal caries who, before admission, used to wear a poroplastic jacket that—never very efficient—had become quite useless through wear and tear, was discharged wearing a leather support. When she attended the clinic some time afterward, she was again wearing the poroplastic jacket. In reply to remonstrances she explained, in a very aggrieved manner, that she wore the poroplastic jacket on week days in order to keep the leather support for best on Sundays."

* * *

IN THE September issue this column contained a whimsical reference to the effect that bobbed hair has on the angle of the nurse's cap, and this calls forth the following from one of the distinguished nurse-educators of the country: "Talk about the angle at which caps are worn not being standardized, what about the cap itself? If one judges by what one sees, it is evident that caps do not conform in any way to any standard! So true is this that one is tempted to ask why caps at all? Time was when they were supposed to 'cover the hair,' 'to protect it from dust,' and 'air-borne germs.' Nowadays does any nurse's cap in any school cover more than a small portion of her hair? In our modern hospitals dust and air-borne germs are in the discard. Why not caps too? I know many will think this unorthodox and heretical, but shocking as it may be, it is rumored that 'bobbed hair held in place by a net' is growing in favor with principals as well as with student nurses. Why not, and if so isn't the cap doomed?"

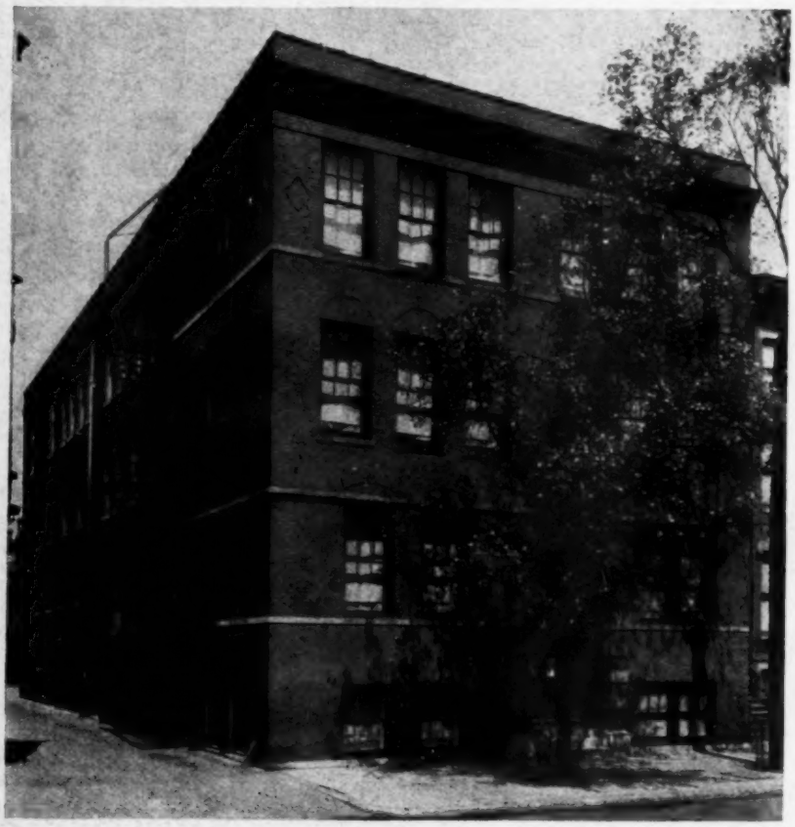
EDUCATIONAL AND COMMUNITY PROBLEMS, NEW HOME FO 1927—FEATURES OF LO

NOTABLE progress in the activities of the American Hospital Association with assurance of far-reaching achievements in the near future marked the twenty-seventh annual conference of the association held in Louisville, Ky., October 19-23. With a registration of over 2,000, according to the executive secretary, a large attendance and a widespread enthusiasm in the foremost hospital problems of the day the convention was generally accorded to have been the most successful yet held.

More than at any previous convention reports of officers and committees evidenced an expansion of the association's activities to the point where it must enlarge physically in order to undertake the increased work outlined.

The steady increase in membership with consequent need for increased services to individual hospitals as well as to hospitals as a whole calls for new forms of activity. The pressing need for a field secretary, the development of the recently established employment bureau as well as the establishment of a legislative reference bureau, the establishment of a budget, and a bureau of research were all given consideration at the meeting.

The affairs of the association for the coming year were intrusted to the following officers: Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, president; Dr. R. G. Brodrick, director, Alameda County Hospitals, San Leandro, Calif., president-elect; Dr. Walter H. Conley, superintendent, Metropolitan Hospital, Welfare Island, N. Y., first vice-president; Blanche M. Fuller, superintendent, Western Nebraska Deaconess Hospital, Omaha, Neb., second vice-president, and W. W. Kenney, superintendent, Victoria General Hospital, Halifax, N. S., third vice-president.



The American Hospital Association's new home located at 18-20-22 East Division Street, Chicago.

Bacon Re-elected Treasurer

Asa S. Bacon who has served the association consecutively as treasurer for the past seventeen years was again unanimously re-elected. Rev. Maurice F. Griffin was re-elected and President Gilmore was elected as members of the board of trustees.

Through the untiring efforts of the local committee in charge of J. D. Gibbs, of the Kentucky Baptist Hospital, every possible courtesy was extended to delegates and an atmosphere of southern hospitality and friendliness pervaded the entire convention. At the opening general session hearty welcome was accorded by the Governor of Kentucky, the Mayor of Louisville and other distinguished citizens who greeted the association in eloquent addresses. The room was filled to capacity with hospital people from all sections of the country who showed an unusual interest in the evening's program.

The program was taken up with addresses of welcome and five committee and executive reports, and messages of greeting from President Coolidge, the Governor General of Canada, the President of Mexico and members who were unable to attend the convention.

The ballroom of the Brown Hotel where the first session was held was filled to capacity with an audience that evinced its interest by remaining throughout the entire program.

The meeting opened with the singing of "America" by the audience. Then followed the invocation by the Right Reverend John A. Floersch, bishop of Louisville, and the addresses of welcome by the Honorable William J. Fields, governor of Kentucky, the Honorable Huston Quin, mayor of Louisville, and John D. Gibbs, chairman of the local committee on arrangements.

In his address of welcome, Governor Fields extended a hearty welcome on behalf of the state, and invited the association members to visit and enjoy its natural beauties. He commended the work that the association is doing in his state and in every state in the country in the terms of reclamation of humanity.

Mayor Quin, in his turn, handed over the key of the city with all its possessions to the delegates during their visit in Louisville. Mr. Gibbs, as chairman of the local committee on arrangements, briefly told what the committee had done in planning the convention and offered to do everything possible to make the week the most enjoyable for the association members.

As a mark of appreciation of the cordiality extended by the Kentucky hosts, President Gilmore, who presided at the meeting, had the audience rise and sing "My Old Kentucky Home."

Response to the addresses of welcome was made by

FOR ASSOCIATION, AND ELECTION OF BRODRICK FOR LOUISVILLE CONVENTION

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, and president-elect of the association, who thanked the distinguished officers for their hearty welcome and briefly told them what the association was doing through the concerted effort of the hospitals of the land to alleviate suffering humanity and what it meant to Louisville and to hospitals to entertain the convention. He called attention to the work of merit being accomplished in the individual hospitals of the city and what this means in the way of community welfare and pointed out the goal for which the hospitals of that city and every city of the country should strive in promoting community health as well as in helping to cure the sick and injured.

In his presidential address, President Gilmore outlined the accomplishments and the objectives of the association. The address appears in full on page 365 of this number.

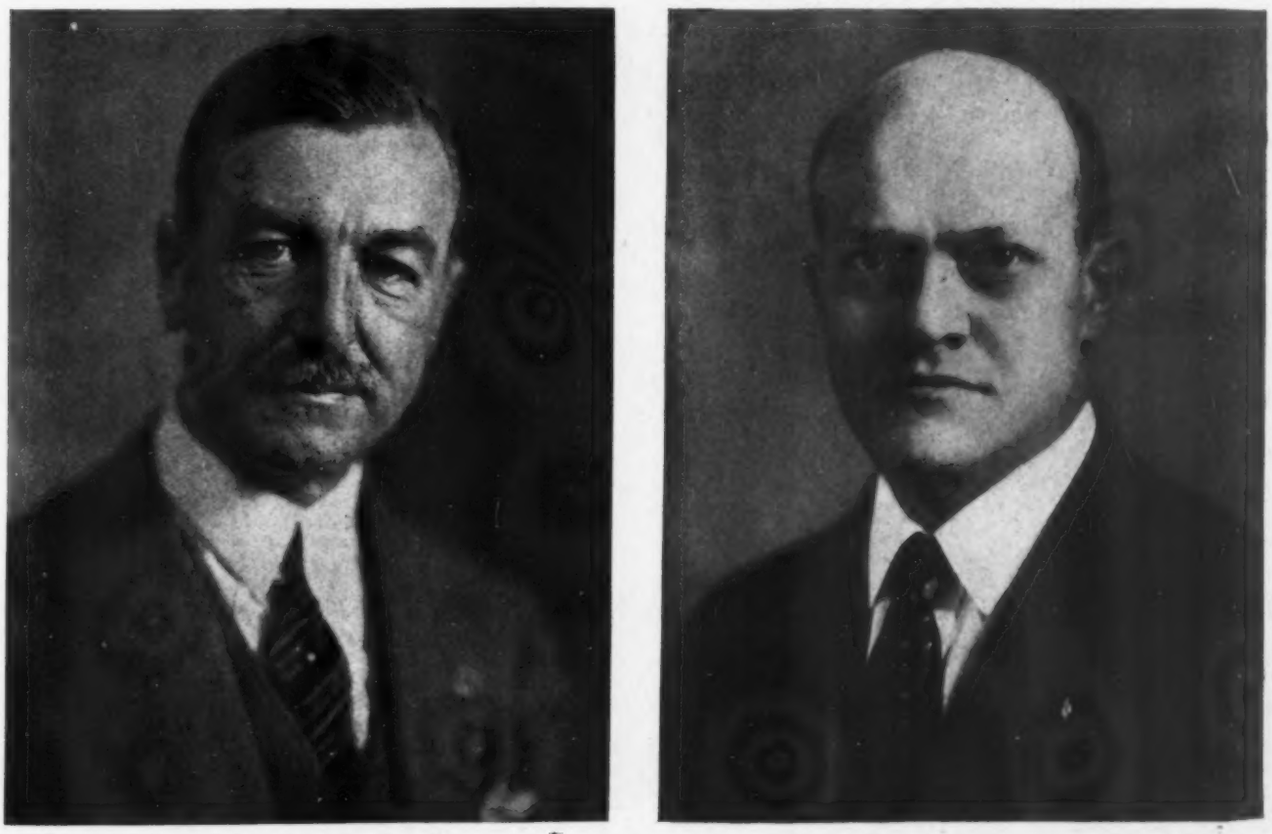
The annual banquet and dance Tuesday evening, the main social event of the convention, proved to be the most successful banquet session ever held. At six-thirty o'clock the ball room of the Brown Hotel was thronged with more than eight hundred guests. The hall was attractively decorated with American and British flags and the tables were bright with bouquets of autumn flowers.

In addition to the regular orchestral music the session was made gay throughout dinner and the program with lively songs led by the scout master of Louisville, with popular songs by the local high school girls' glee club, and with negro spirituels by a colored choir of the city.

As soon as guests were grouped at the tables the invocation was given by Dean C. R. Hemphill of the Presbyterian Seminary, Louisville. At the banquet table were seated the officers of the association, foreign guests and representatives of allied organizations. The two foreign representatives were George C. Potter, superintendent, Queen's Hospital, Honolulu, Hawaii, and Dr. Foiston Reitz, chief surgeon, County Hospital, Barnaimo, Sweden, both of whom expressed their appreciation of the welcome given by the conference, paid tribute to the work of the American hospitals, and told something of hospital work in their respective countries. A message of greeting was read by President Gilmore from Dr. Faulkner, superintendent, Dunedin Hospital, Dunedin, New Zealand, expressing regret that he was unable to attend the association meeting this year and wishing the association every success in its work.

The following guests responded on behalf of allied organizations:

Col. John B. Huggins, St. Louis, Mo., representing the medical department of the U. S. Army; Dr. E. H. Mullen, Louisville, the U. S. Public Health Service; Dr. H. E. Whitledge, the U. S. Veterans' Bureau, Washington, D. C.; Eleanor C. Vincent and Dr. William R. Redden, the American Red Cross; Dr. N. P. Colwell, Chicago, the American Medical Association; Dr. S. S. Goldwater, New York, the American Conference on Hospital Service; Mary E. Roberts, the American Nurses' Association, and



The two leaders who will guide the association through the next two years. (Left) Dr. R. G. Brodrick, director of hospitals, Alameda County Hospital, San Lenardo, Calif., chosen president-elect, and Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, president for the coming year.

Dr. M. T. MacEachern, Chicago, the American College of Surgeons.

The address of the occasion was "The Doctor,—Past, Present and Future," delivered by Dr. E. R. Palmer, president, Jefferson County Medical Society, Louisville, who gave an eloquent presentation of the evolution of modern medicine comparing it step by step with that of the evolution of life processes, showing the consequent development in the work of members of the profession. As the science of medicine has gradually become more highly specialized with the development of microscopic anatomy, bacteriology, x-ray technique, said Dr. Palmer, so it is with members of the profession. No longer are they a group of isolated country doctors with but a few leaders, but rather specialists each striving to perfection in his chosen field. Dr. Palmer continued tracing the development of medicine into the future when he believes that super-specialization will be the culmination of the development of medical science. He predicts that ninety per cent of the diseases to which mankind is at present addicted will be stamped out through the research of super-specialists logically supplemented by the work of preventive medicine.

President Gilmore, whose guiding hand directed the sessions of the twenty-seventh conference.

At the close of Dr. Palmer's address C. J. Cummings, Tacoma, Wash., chairman of the National Hospital Day Committee presented the certificate of award for the best National Hospital Day celebration to Mary E. Henry, (in absentia) superintendent, Pottstown Hospital, Pottstown, Pa. Mr. Cummings also made formal announcement of his withdrawal as a nominee for the office of president-elect of the association.

Dr. George C. Potter, superintendent, Queen's Hospital, Honolulu, who represented Hawaiian hospitals at the conference.

At the close of the program the hall was cleared for dancing and a large representation of the assembly danced until the music stopped at one o'clock.

This year state and sectional groups were bound closer together than at previous conferences by the group meetings. In the exposition hall several state associations had individual booths where members gathered to talk over their problems and to visit, and many luncheons and breakfasts were held by these groups.

The Ohio Hospital Association met at the Seelbach Hotel for luncheon October 20; the Hospital Association of the State of Illinois met at breakfast October 21; the Michigan Hospital Association met at luncheon October 21; the Pacific Coast representatives also met.

Another striking evidence of the "get together" feeling that was uppermost at the conference was a meeting of women superintendents. A health council meeting was also held under the direction of Miss Anna C. Phillips, executive secretary, Health Council of Louisville.

That the association and its members are endeavoring to spread the message of the hospital to the public and are broadening their public contacts through various organizations was evidenced in the invitations from various clubs to entertain a representative of the association. In this connection Dr. A. C. Bachmeyer addressed the local Kiwanis Club; President Gilmore, the Rotary Club; Robert E. Jolly, superintendent, Baptist Hospital, Houston, Texas, the Lions Club; Dr. W. P. Morrill, superintendent, Columbia Hospital, Washington, D. C., the American Legion; Dr. Paul W. Wipperman, superintendent, Decatur and Macon County Hospital Decatur, Ill., the Elks Club; C. J. Commings, the Cooperative Club; John E. Ransom, Chicago, Ill., the Optimist Club; Matthew O. Foley, managing editor, *Hospital Management*, Chicago, the Exchange Club; and Sally Johnson, director of nurses, Massachusetts General Hospital, Boston, Altrusa Club.

Local and state allied groups held various social events for their sister organizations during the conference. The Kentucky State Nurses' Association served tea on October 22, to all nursing and hospital workers and following the tea the Western District Nurses' Association entertained with a ride in the parks.

Dr. E. R. Palmer, president, Jefferson County Medical Society, Louisville, who delivered the address at the annual banquet session.

Visiting dietitians were entertained by the Dietetic Club of Louisville at tea, October 21. Architects at the convention were entertained at luncheon by the Kentucky Chapter of the American Institute of Architects.

As a recognition of the far-reaching influence of the association and its achievements, the Smithsonian Institution, Washington, D. C., has invited the association to establish a permanent exhibit in the institution to consist of transparent photographs illustrating the various interesting phases of hospital activity. Superintendents are thus urged to cooperate by collecting representative pictures of activities in their institutions to be included in this collection.

Standing Committees

The following standing committees were appointed by President Bachmeyer at the closing session of the conference:

Constitution and rules: Richard P. Borden, trustee, Union Hospital, Fall River, Mass., chairman; the Rev. H. L. Fritschel, president, Milwaukee Hospital, Milwaukee, Wis., and Emily Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore.

Legislation: Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago; chairman; Dr. W. P. Morrill, superintendent, Columbia Hospital, Washington, D. C., and Dr. B. W. Caldwell, Iowa City, Ia.

Resolutions: Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo., chairman; Dr. Harold W. Hersey, superintendent, Bridgeport Hospital, Bridgeport, Conn., and Dr. Stewart Hamilton, superintendent, Harper Hospital, Detroit, Mich.

Membership: Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., chairman; Dr. F. R. Nuzum, Santa Barbara Cottage Hospital, Santa Barbara, Calif.; Charlotte Jane Garrison, superintendent, Polk County Public Hospital, Des Moines, Ia.; May A. Middleton, superintendent, Methodist Episcopal Hospital, Philadelphia, and Dr. W. W. Leake, superintendent, Charity Hospital of Louisiana, New Orleans, La.

Out-patient: Dr. Alec N. Thompson, medical secretary, Committee on Dispensary Development, New York, chairman; Dr. J. L. McElray, director, St. Mark's Hospital, New York, Dr. Donald C. Smelzer, assistant superintendent Buffalo General Hospital, Buffalo, N. Y., and Boris Fingerhood, superintendent, United Israel-Zion Hospital, New York.

Accounting and records: H. J. Southmayd, Welfare Federation of Cleveland, Cleveland, chairman; Frank Chapman, director, Mount Sinai Hospital, Cleveland, and G. W. Curtis, superintendent, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

Flooring: Frank E. Chapman, chairman; Charles H. Young, superintendent, Maine General Hospital, Portland, Me., Dr. Thomas Howell, president, Society of the New York Hospital, New York, Perry W. Swern, Chicago, and Myron Hunt, Los Angeles, Calif.

Public Health: Dr. A. J. Chesley, secretary and executive officer, Minnesota State Board of Health, St. Paul, Minn., chairman; Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York; Dr. C. G. Parnall, superintendent, Rochester General Hospital, Rochester, N. Y.; Dr. R. G. Leland, Columbus, Ohio, and Dr. W. S. Rankin, State Board of Health, Raleigh, N. C.

Training school budgets: Dr. George O'Hanlon, superintendent, Bellevue Hospital, New York, chairman; Elizabeth Greener, director of nurses, Mount Sinai Hospital, New York; Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que.; Dr. W. G. Neally, superintendent, Brooklyn Hospital, Brooklyn, N. Y.; Sister Hortense, St. Elizabeth's Hospital, Youngstown, Ohio; Ethel Swope, assistant superintendent, Methodist Hospital of Southern California, Los Angeles, and Dr. W. G. Neally, superintendent, Brooklyn Hospital, Brooklyn, N. Y.

Two well-known dietitians: (left) Lulu G. Graves, honorary president, American Dietetic Association, and Fairfax Proudfit, dietitian, Memphis General Hospital, Memphis, Tenn.

General furnishings and supplies: Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn., chairman; D. C. Shepard, president, St. Luke's Hospital, St. Paul, Minn.; Dr. Paul W. Wipperman, superintendent, Decatur and Macon County Hospital, Decatur, Ill.; John M. Smith, director, Hahnemann Medical College Hospital, Philadelphia; and Clara B. Peck, superintendent, House of Mercy Hospital, Pittsfield, Mass.

Foods and equipment for food service: Paul E. Fesler, superintendent, University Hospital, Oklahoma City, Okla.; H. E. Bishop, superintendent, Robert Packer Hospital, Sayre, Pa.; Mary A. Jamieson, superintendent, Grant Hospital, Columbus, Ohio; Sister Ambrose, Mercy Hospital, Scranton, Pa.; James U. Norris, superintendent, Woman's Hospital of the State of New York, New York; Alice Gaggs, superintendent, J. N. Norton Memorial Infirmary, Louisville, Ky., and W. W. Rawson, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah.

Clinical and scientific equipment and work: Dr. K. H. Van Norman, superintendent, Western Reserve University Hospitals, Cleveland, chairman; Annette B. Cowles, superintendent, Children's Free Hospital, Louisville, Ky.; C. A. Lincblad, superintendent, Millard Fillmore Hospital, Buffalo, N. Y.; Mary E. Surbray, superintendent, St. Luke's Methodist Hospital, Cedar Rapids, Ia., and Joseph J. Weber, director, Grace Hospital, New Haven, Conn.

Ten Architects on Committee

Buildings, construction, equipment and maintenance: Dr. S. S. Goldwater, chairman; and the following architects: M. B. Biscoe, Denver, Colo.; Charles F. Butler, New York; Richard E. Schmidt, Chicago; L. F. Franklin, New York; W. C. Hill, Boston; Myron Hunt, Los Angeles; Albert Kahn, Detroit, Mich.; M. B. Medarry, Philadelphia; James Gamble Rogers, New York, and Edward F. Stevens, Boston.

The committee on the training of hospital executives was reappointed and the intern committee will be announced later.

HOSPITAL SUPERINTENDENTS, NURSES, DIETITIANS AND THEIR FRIENDS ENJOY BANQUET OF THE TWENTY-SEVENTH ANNUAL CONVENTION

CLOSER RELATIONSHIP OF COMMUNITY AND HOSPITAL IS EMPHASIZED

Reported by R. G. Brodrick, M.D., Director of Hospitals
Alameda County Hospital, San Leandro, Calif.

THAT there is a greater realization of the close connection between the hospital and the community, and that to succeed the hospital must be the center of all community health problems was demonstrated at the convention by the interest shown in the many excellent papers and reports on questions that directly or indirectly affect both the community and the hospital. In many cases the responsibilities of health problems were put squarely up to the hospital and the progress that was made toward solving these questions was encouraging.

The community point of view in relation to the hospitals was discussed not only by physicians and superintendents of hospitals but by health authorities and by laymen working in some activity closely allied with health and hospital problems.

It was because of this wide range of professions among the speakers that the value of close cooperation between the hospital and the community was so greatly emphasized. Community chest representatives, hospital fund directors, state health officers, county hospital superintendents and hospital executives joined in the discussions that made up these features and gave a broader aspect to the subject.

Perhaps it was more beneficial that all of these papers were not read at any one session but were distributed throughout the program. Some of them were presented at a session on Wednesday morning, others on Wednesday afternoon and the remainder on Friday at the morning and afternoon sessions. Again it was notable that the speakers came from different geographic locations in the United States. New York City, the Pacific Coast, the far south and other portions were represented to a greater extent than ever before.

Two prominent delegates from California: President-elect Brodrick, and (left) Myron Hunt, architect, Los Angeles.

Chronic Diseases and the Community

Wednesday morning's general session was devoted to three papers on subjects of especial interest to the field and to the reports of two committees. The session opened with a paper on "Chronic Diseases—A Challenge to the Hospital and the Community," by Dr. Ernst P. Boas, medical director, Montefiore Hospital, New York.

The paper ably demonstrated the far-reaching implications of the chronic disease problem and indicated its points of contact with the general hospital. The problem is one of increasing importance because of the lengthening span of life, for those most often afflicted with chronic diseases are the middle-aged and elderly.

"The hospital does not provide adequately for these chronic individuals," said Dr. Boas, "nor does the dispensary although one-half of all dispensary patients belong in this category. One chronic patient may occupy for three months a hospital bed that could in the same period have served eight or nine acute medical or surgical cases, which are the legitimate type of patients for the general hospital." Dr. Boas therefore feels that it is natural for hospitals often to refuse admission to chronic patients but he is not in sympathy with the lack of interest shown toward such cases as are admitted, and deplores the attitude of hopelessness and impatience often shown toward these sufferers.

The attitude of hospitals and the community in general toward the chronic patient has arisen largely through ignorance, for it is not realized that from fifty to seventy-five per cent suffering from chronic diseases need care such as can be provided only in a general hospital. Not a few of these patients can be rehabilitated in part, at least, and returned to their homes. In most instances suffering can be relieved and life prolonged by careful medical attention; in others skilled nursing is essential. "Humanity demands," said Dr. Boas, "that these unfortunates be given all of the medical and nursing relief that they may need."

Many patients with chronic diseases, after they have been properly studied and treated in the hospital require custodial care. Dr. Boas suggests that these individuals should be housed in custodial wards, operated in organic connection with a hospital service so that the patients can be freely transferred back and forth when need arises.

It is highly probable that in many cases if a sufferer from incurable disease had received institutional care for a period of from three to six months at the onset of his illness his disease could have been arrested and he could have been restored to a useful and active life.

Chronic patients are found in four different types of institutions: In the general hospital; in the almshouse; in the home for incurables and in the home for the aged, but all of these institutions serve them only as refuges without meeting their needs. The patient with a chronic ailment is a sick man for whom the proper type of institutional relief has not yet been provided.

Adequate provision for the many sufferers from chronic diseases demands the establishment of institutions specially adapted to their needs. These institutions will be hospitals for chronic diseases in the fullest sense and will consist of a hospital division and a home division, both under the same management and in close geographical relationship to one another. They will serve not only the destitute, the almshouse population, but families with modest incomes as well. The average wage earner can meet the costs even of a severe illness if it lasts but a few weeks but when physical incapacity extends over a period of many months funds become exhausted and the patient suffers from lack of medical attention.

The establishment and support of such institutions will be a formidable expense, and while private philan-

thropy may provide the buildings, the wherewithal to maintain them must come from the community, as is the case with hospitals for the insane and tuberculous, which are supported in the majority of cases by public funds.

The thorough way in which Dr. Boas presented the subject aroused much informal discussion on the hospitalization of chronics and invalids. The question was asked as to what percentage of chronics could be restored to productive life if adequate hospitalization were provided. Dr. Boas answered that the percentage could not be determined, as relatively few could be restored to normal production but could be greatly aided by proper care in a convalescent home and that their morale could be much improved by rehabilitation work. The discussions brought out the fact that too many hospitals are compelled to house chronic patients thereby keeping out acute cases, which should be of first consideration, because of the lack of adequate facilities for chronic patients and convalescent homes for special types of cases, such as cardiacs.

Much Interest in County Hospitals

Much enthusiasm was shown by the large audience at the meeting in the subject of county hospitals, prompted by the paper presented by Dr. R. G. Brodrick, that appears in full on page 386.

Dr. Brodrick's paper was discussed by Frank Chapman, director, Mount Sinai Hospital, Cleveland, who said that the county hospital was undoubtedly one of the biggest hospital problems the country has to face, since forty-five per cent of the counties in this country do not have such facilities. He commended Dr. Brodrick's work in the development of the Alameda County group and made a plea for extending the facilities of county hospitals to all practitioners in good standing.

Dr. C. W. Munger, director, Grasslands Hospitals, Valhalla, N. Y., made a motion that the association appoint a committee to study county hospitals plans.

"There is hardly any institution in the social structure that has so many community responsibilities of so vital a character as has the modern hospital," said Dr. E. H. Lewinski-Corwin, director, Hospital Information Bureau, New York, in discussing the subject of "The Community Policy of Hospitals."

Of the many obligations of the hospital to the community Dr. Corwin took up the following:

(1) Policy. An intelligent policy must be formulated and its first requirement is a knowledge of the morbidity prevalence, the housing and social conditions and the extent and character of already available hospital and public health services. The present and future need for various types of accommodations should be ascertained, and provision should be planned for chronic and convalescent patients. Consideration should be given to the relation of the hospital to its patients, its staff, to welfare agencies and to the medical profession generally.

(2) Discharge of implied moral obligation. The community assumes that the hospital staff, both professional and lay, is selected solely on the basis of merit and is carefully supervised, so that negligence or discourtesy will not be tolerated in the hospital. It is the hospital's duty to see that this assumption is warranted by facts.

(3) High type of performance. The assurance to the community that the practice of medicine in the hospital is of the highest type attainable and that it sets the pace and promotes the best type of general practice in the community forming the civic responsibility of the hospital.

(4) Broader hospital opportunities for physicians. The hospital owes it to the advance of medical science to supply physicians with opportunities of periodical contact with the best hospital practice and to offer these opportunities to a larger number of physicians than is now the case. It should make more generally available its facilities for diagnostic services and for teaching.

(5) Delimitation of responsibility for nurse training. In order to refute unjust criticism the hospital should make an effort to present the nursing situation clearly to the public and define the extent of its community obligation in the matter. The difficulty of obtaining an adequate supply of competent nurses is constantly increasing, but the forces governing the demand and supply of nurses are beyond the control of hospitals. The hospitals should make the community recognize this fact and should discharge its civic obligation by providing the best facilities possible for the training of nurses and should make the working conditions as attractive as possible.

(6) Availability of hospital facts. The annual report is the point of contact between the hospital and the community, and should therefore properly interpret what the hospital has accomplished during the year in the realm of medical and surgical services as well as in the more stereotyped departments. The community should be informed of the real problems and achievements of its hospitals. In this connection Dr. Corwin spoke of the need for establishing a uniform rule of statistical procedure in order to have some basis for vital comparisons which would make the cumulative experience of hospitals available. As it is this vast and import reservoir of information cannot be fully utilized. Dr. Corwin quoted statements by eminent surgeons which show the need for such a service.

Provision for Convalescents

(7) Provision for institutional convalescence and for the reclamation of the "chronics." Often good accomplished in the hospital is partially undone by the lack of convalescent care. The extension of institutional convalescence where such is needed must be directly or indirectly provided by hospitals, and the movement for it is gathering momentum. Unfortunately this is not true of provision for the chronically ill and hospitals should not shirk their responsibility in providing for the care of this huge group of sufferers.

(8) Provision for contagious disease isolation. Dr. Corwin quoted as follows from a recent issue of *Health News*, the bulletin of the New York State Department of Health: "There should be provided in every city, by some means, a place in which cases of communicable disease may be isolated and cared for in emergencies. If there is a general hospital this would seem to be the logical place."

(9) Participation in Health Promotion. The hospital should take an active and direct part in the movement for periodic medical examinations and should place its facilities at the disposal of this important health crusade.

In discussing Dr. Corwin's paper on the community policy of hospitals, Dr. Goldwater said: "The hospital program should be based on a comprehensive view of the comunity's needs and should then provide the needed facilities for treatment, education and research." From the community's needs and should then provide the needed falooked upon as the most persistent beggar and the most successful tax dodger of any institution in the community, and that in the future the hospital would be called upon

to render a fuller account of its services to the community.

"It is not time that hospitals should realize their responsibility to the community for the prevention of disease and the promotion of health?" so said Dr. Howard Childs Carpenter of the Children's Hospital of Philadelphia, in his paper on "The Responsibility of Hospitals in the Prevention of Disease."

Hospitals and Disease Prevention

Dr. Carpenter feels that every general hospital, be it large or small, should have a department for the prevention of disease. Even special hospitals should have such a department; especially all maternity hospitals and children's hospitals because the younger the patient the more effective are the results to be obtained in preventive medicine. In maternity hospitals the results are best secured through prenatal work.

Among the responsibilities of a hospital to its community Dr. Carpenter touched upon the following: The improvement of the sanitary conditions surrounding the hospital; the control of communicable diseases; the hospital should cooperate with the health department in the preventing the spread of contagion and should make available proper isolation for patients with infectious diseases; the hospital should conduct health examinations for adults at least once a year, for school children every six months, for pre-school children every three months and for infants once a month; public lectures on health and disease prevention should be arranged by the hospital and free health literature distributed; it should also make available to the people a free medical reference library, exhibitions of charts and models teaching health and motion picture exhibitions on health topics; the hospital has a responsibility, too, as a teaching center for many groups.

Dr. Bert W. Caldwell, Iowa City, Ia., a member of the legislative committee.

In the nurses' curriculum the important subject of preventive medicine has been largely overlooked, the speaker said. If the hospital's responsibility is to train nurses adequately for the care of the sick, it is just as much a responsibility of the hospital to train them for public health nursing, for the public health nurse is our greatest instrument in preventive medicine.

In the education of the intern, too, training in preventive medicine is highly important and the hospital has a duty to perform here, as prior to coming to the hospital the intern seldom has any instruction on this subject.

Another responsibility that the hospital has is that of scientific research in the prevention of disease. The development of the present social service department into a department for the prevention of disease, under medical direction, would open a wonderful opportunity for its staff of physicians, social workers and nurses to disseminate the knowledge of the prevention of disease by medio-sociological research. The great mass of people do not understand what a hospital really stands for or what its functions are. Most of them believe it is a place to go for operations. The fault lies with the hospital managers, who have failed to realize the need of educating the public as to how the hospital can serve them.

Dr. Carpenter visions the time when some well equipped hospital, with a progressive board of managers, and a wide-awake medical staff, will be devoted wholly to the prevention of disease and will use its entire resources to this end. To this hospital patients will not be admitted for curative purposes for the whole time and energy of the staff will be concentrated on the prevention of disease. Such a hospital, said Dr. Carpenter, would do more than any one other thing to stir up this country to the fact that disease can be prevented and practically all the diseases of childhood eliminated.

In discussing Dr. Howard Childs Carpenter's paper on "The Responsibility of Hospital in the Prevention of Disease," Dr. A. Graeme Mitchell, Cincinnati General Hospital, Cincinnati, said, "The importance of preventive medicine is becoming so well recognized that it is difficult to realize the obstacles the pioneers of this development had to overcome. What Dr. Carpenter really wishes is for the hospital to do its utmost to work itself out of a job, to do everything to keep the public so well that the hinges of its doors will last longer and its ward beds will not wear out so quickly. It seems as though sane thinking will eventually lead us to do as Dr. Carpenter suggests and that prevention of disease will be part and parcel of the work of hospitals if not their main function.

"Think of the benefits derived by the public when patients discharged from the hospital can be followed and guided and instructed by a corps of well-trained workers including doctors and nurses," Dr. Mitchell said, in pointing out the future course of the hospital in health education and in the prevention of disease.

"The Relation Between the Hospital and the Community Chest," was the subject of the paper by Raymond Clapp, director, Welfare Federation of Cleveland, who described the work that is now being accomplished by the American Association of Community Organizations in making an experiment in studying the volume and cost of social work in fifty of the larger American cities, which includes two-thirds of the cities of over 100,000 population.

The information to be secured includes the total expense of services in the fields of family welfare and relief, child care, hospitals and health promotion, recreation and character building such as are usually financed through community funds and welfare federations. This information is being secured in such a way that it is possible to compare not only the total expense of these services for the various cities but the cost of care in the various institutions and the cost of character building in various communities. The services are thus classified into forty groups. In addition to expense, income is classified into contributions, endowment earnings, payments for service rendered and public revenue. Mr. Clapp illustrated his paper with twelve charts comparing the results of the investigation.

The paper was discussed by Frank E. Chapman who spoke of the development and results of community chest work, pointing out that before community chests were established the ratio of the earned to the subsidized dollar was higher than it is now in the various subsidized hospitals where the percentage of unearned income has been rising.

This indicates, he said, that the more help that is given the greater is the dependence upon such aid.

"The problem in community chest work today," said Mr. Chapman, is that of curtailing the requests to fund raising agencies so that the subsidy may be apportioned in the way in which it will best serve the community's needs."

The local angle to the problem was given by Annette B. Cowles, superintendent, Children's Free Hospital, Louisville, Ky., who strongly commended the community chest as it operates in that city. She said that the chest had cooperated with her hospital in every way possible and had not interfered with its administration. However, she said that there was a feeling on the part of some people that the community chest plan robs them of the personal contact with the hospital so strongly felt under the old decentralized method of procuring funds.

The conflict that exists between health agencies and the overlapping of spheres in public health work was ably described by Burdette G. Lewis, commissioner of institutions, Trenton, N. J., in his address on "Institutions as Centers for the Prevention of Disease."

Mr. Lewis clearly defined the ways by which hospitals and sanitariums can extend their disease prevention work for the benefit of the community. He said that many state institutions, particularly those for the mentaly ill, could provide room for clinics for common use. There is particular need for this in the New York institutions, he pointed out, since last year there were 44,000 patients in insane institutions while 57,000 came to clinics voluntarily for diagnosis. He described the conflict that exists in many cities between the public health and educational agencies over who will treat the school and pre-school child. The same war exists between city and state agencies in clinic work.

In view of this situation, Mr. Lewis said that we can never get cooperation between the public and private agencies until we have a fact basis built upon research. In order to get this he advocated a central research council plan to determine what classes of work are to be done, and where and when they are to be accomplished.

The subject was discussed by Dr. P. W. Wipperman who expressed his appreciation of Mr. Lewis' excellent interpretation of the problem and advocated the plan, now in operation in a few cities, by which one official is in charge of the public health work and school hygiene of the city. This system alleviates the conflict between agencies by centralizing the control of these activities.

With respect to tuberculosis prevention he said that the county sanitarium should be the logical center for such preventive work, and that from there the community can best be taught prevention by the visiting nurses who go directly into the homes. He pointed to the work that is now being done by sanitariums in Illinois under the Glacken Tuberculosis Act, which has proved to be a model plan for preventive work. Under this law the county institutions are aided by a special sum appropriated for tuberculosis preventive work.

The session ended with the reelection of the section officers.

HOSPITAL EXHIBITORS' ASSOCIATION AN ACTIVE FORCE AT THE MEETING

MUCH credit is due to the Hospital Exhibitors' Association for its efforts in making the exposition a success from every standpoint. All during the conference members of that body did much to further the friendly relationships between the exhibitors and delegates and enthusiastically promoted, and participated in, the social events of the week.

The annual banquet of this association was held Thursday evening, October 22 at the Brown Hotel. The A.H.A. guests of honor were: President Gilmore, President-elect Bachmeyer, Dr. William H. Walsh, executive secretary, and John E. Ransom, editor of the conference *Daily Bulletin*.

At the banquet the officers for the coming year were elected. Edward Johnson, New York, was elected president for 1926 and Lawrence Davis was reëlected secretary-treasurer. B. A. Watson, who has been president of the association, was elected chairman of the committee in charge. The two new members of the committee are Thomas Rudesill and Will Ross who were elected to fill the vacancies left by Paul Esselborn and Sherman Sexton. L. C. Walker was also reëlected to the committee.

The picture shows a representative group of the exhibitors' association who formed the committee on exhibits for this year's meeting.

(Left to right): Paul Esselborn, Lawrence Davis, secretary-treasurer, B. A. Watson, retiring president; Edward Johnson, chairman of the committee; J. B. Myers, L. C. Walker, Sherman Sexton, and H. R. Applegate.

VITAL PROBLEMS OF ADMINISTRATION WELL DISCUSSED BY SUPERINTENDENTS

Reported by Joseph C. Doane, M.D., Medical Director,
Philadelphia General Hospital, Philadelphia

A SURVEY of the program prepared for the twenty-seventh conference of the American Hospital Association would quickly disclose the fact that an important place was given to a discussion of administrative problems. Administration was assigned three sessions, at which were presented many major problems which puzzle the administrator.

The first session, on Tuesday afternoon, brought out a very large attendance and the first papers were those covering certain committee reports, including the report of the special committee on cleaning of which Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., was chairman. The report consisted chiefly of a summary and final statement of the very careful and painstaking work of the committee for the past three or four years. Dr. Munger called attention to the fact that he felt that the committee's function had been fulfilled, and after statements of appreciation had been made by several of those in the audience, it was moved that the committee be discharged from further consideration of this subject and thanked for its work in the past.

Dr. Joseph C. Doane, medical director, Philadelphia General Hospital, Philadelphia, and chairman of the administration section (left) and Dr. Samuel W. Hamilton, director, Division of Hospitals, National Committee for Mental Hygiene, New York.

A more comprehensive statement of the report follows:

The committee on cleaning reported that particular interest had been given the subject of misbranded preparations, following the testing of a large number of products indicating that the advertisers' claims could not be relied upon. Definite statements on that subject were not made partly because the committee did not have the financial resources to conduct tests and partly because it did not deem it wise to shoulder the responsibility that it would incur if it tried to point out misrepresented products.

It recommended promotion of wider use of specifications in the purchase of cleaning compounds in order to save hospitals from exploitation at the hands of dishonest manufacturers.

The committee on general furnishings and supplies reported on the work accomplished in the last year with respect to chinaware, linen, beds, and bed blankets.

After a study of hotel chinaware recommended by the U. S. Department of Commerce, the committee recommended further elimination of varieties. A restricted list of china was exhibited at booth 63.

In the study of hospital linen, the committee found eleven sizes of bed sheets, twenty different sizes of pillow cases, twenty-two sizes of bed spreads, twenty-nine sizes of bath towels, and thirty sizes of face towels. After further study this data will be presented to the Department of Commerce.

Through the work of the committee and other agencies the Department of Commerce has effected the standardization of beds to three sizes for general hospital use and a reduction of the varieties in bed blankets from seventy-eight to twelve.

The committee repeated the recommendation made at the previous convention, namely, that a technical expert be employed to work with the special committee in connection with the Federal Specifications Board to study supplies whose simplification may be of economic value to hospitals.

The report of the committee was discussed by Dr. Malcolm T. MacEachern who commended the work done by the committee and pointed out the economic advantages of standardization of supplies. He said that several complaints had been made by some people that we were tending toward overstandardization of supplies. This criticism is unwarranted, however, he said, as the standardization of beds blankets, sheets, and such commodities is necessary as an economic measure both for the manufacturer and the hospital. He expressed the hope that the committee would continue its work in close association with the Division of Simplified Practice of the U. S. Bureau of Standards. The report was also discussed by R. M. Hudson, chief, Division of Simplified Practice, who advocated the standardization of grades and qualities as well as sizes of commodities, since under the present conditions jobbers have to keep every conceivable size and quality of products in stock.

The report of the committee on clinical and scientific equipment and work was presented by Dr. K. H. Van Norman, director, Western Reserve University hospitals, Cleveland, Ga., chairman of the committee.

During the past year the committee has given consideration to the following subjects: anesthesia; laboratory equipment for a one hundred bed hospital and standardization of biological stains. These three subjects were studied and reports thereon written by, respectively, Dr. Winford H. Smith, director Johns Hopkins Hospital, Baltimore; Dr. R. G. Brodrick, director of hospitals, Alameda County Hospital, San Leandro, Cal., and Dr. M. F. Steele, superintendent, Hope Methodist Hospital, Fort Wayne, Ind.

On the subject of anesthesia an inquiry was addressed to two groups of hospitals: those with one hundred beds or less, and those with one hundred beds or more. Reports were received from twenty-seven in the former group and from forty-one in the latter group. The data gathered from this inquiry was compiled and was presented in detail in the report.

The second section of the report gave a comprehensive list of laboratory equipment for a one hundred bed hospital.

In the third section of the report, "The Standardization of Biological Stains," reference was made to an article dealing with this subject that appeared in the *Journal of Bacteriology*, vol. 7, January, 1922. The article embodied the results of an exhaustive bit of research pro-

moted by the committee on bacteriological technique of the Society of American Bacteriologists. Some thirty workers were engaged in this research work and they used and tested various stains and made reports on them. The prime factor derived from these tests gave to the laboratory worker a clear insight into the value of the stains of different manufacturers when used in the staining of bacteria. It is noteworthy that the American stains were found in many instances to be superior to the pre-war German stains. No standards by which future stains could be tested were set up, however, as a result of this research and generally speaking the stains were not tested from the chemical standpoint which is really the most important factor. Such standards are necessary, the report stated, so that laboratories may have some suitable and chemical biological standard by which various dye stuffs can be tested and made uniform.

The committee's report, in part, reads as follows:

"William H. Bell of the laboratories of the Coleman & Bell Company, Norwood, Ohio, quotes the following, 'It must be understood that the biological staining tests are more in the nature of suggestions than anything else, since it would be obviously impossible to test out a staining solution under all the various possible modifications which the literature gives.' He believes that a stain which will pass the specifications set out in their laboratories will be perfectly satisfactory as a general biological stain. Additional standards for stains will be necessary, however, to be set up until all specifications for the commonly used stains have been completed.

S. G. Davidson, superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich., and Mrs. Davidson.

"The National Research Council does not carry on the work of standardization of stains but it seems to be a fixed policy of this council to take part only in the assistance of scientific projects in their beginning and to withdraw when such projects are well started so that they can be able to carry on new and desirable projects brought before it. The council has, therefore, withdrawn from the work which is being done on stains, not from lack of interest, but because the work can now justify an independent existence.

"An independent commission has been formed, which is composed of a number of biologists who have been associated together in this work. There are about sixteen investigators who are members of this commission, the executive committee of which is composed of men such as H. J. Conn, J. A. Ambler, S. I. Kornhauser, F. W. Mallory, and L. W. Sharp.

"In order to make clear the vast importance of the part which biological stains play in the public health, I will give an illustration or two in the laboratory. The bacteriologist has before him a culture of diphtheria stained with some dye which, as a rule, is methylene blue. If, on the other hand, he has a discharge of some sort which may be suspected of being gonorrhea, another special stain such as the gram stain is used. In other words, bacteria treated in this way will stain with another dye after being previously decolorized. Another striking example is the examination for the tubercle bacillus where fuchsin is used in staining the sputum submitted after which a mixture of acid and alcohol and restaining with methylene blue. The tubercle organism retains the red of the fuchsin while other organisms lose it and appear blue with the latter stain. The use of dyes is also becoming a very important agent in therapeutics, the treatment of septicemia, nose and throat infection, and syphilis. Salvarsan is a dye and many similar drugs recently produced are either dyes or closely related to them.

"The conclusion of the committee report was as follows:

(1) That imported stains available before the war were not necessarily constant because they bore the name of the same firm.

(2) That there is no evidence that stains imported today are the same as those obtained before the war.

(3) If the quality of stains is to be kept under scientific control, there is much more promise of doing so with the cooperation of domestic concerns than through dependence upon the foreign markets."

In presenting the report of the committee on accounting and records Dr. A. C. Bachmeyer said that the committee had been instructed to compile the four previous reports into one document but that as the members were unable to give the required time to the compilation the committee would present the combined work next year. He said that with respect to the working out of an elaborate accounting system, for which the committee has had many requests, that it was deemed unwise and impractical for the adoption of such a system in hospitals as a whole, since eighty per cent of the hospitals of the country are small hospitals.

A subject that has been discussed pro and con at many previous hospital meetings, minor and major throughout the country, was introduced by Dr. W. L. Babcock, director, Grace Hospital, Detroit. I refer to the question of the advantages to be gained by hospitals through cooperative purchasing. That the discussion of the topic was of much practical concern to hospital administrators generally was demonstrated by the interest that was displayed in the subject as it was developed by Dr. Babcock and succeeding speakers.

Dr. Babcock traced the history of cooperative buying in state controlled institutions in his paper entitled, "Cooperative Buying for Hospitals." He showed how the purchasing of beef, coffee and tea has proved advantageous by contracts made between the state and the primary source of supply.

He cited the Hospital Bureau of Standards and Supplies that in 1909 engaged an expert purchasing agent to buy bulk commodities for New York hospitals and later extended this service to other institutions outside of the metropolitan area.

Dr. Babcock said that attempts in other centers, however, had been failures but gave as an example of successful cooperative buying the hospitals of Cleveland and referred to the article on this subject on page 22 of volume XXI of THE MODERN HOSPITAL.

He said that in other places the community fund purchasing bureaus have not been successful and that failure was due to one major cause, to wit, that the communities that support hospitals, had objected to this form of purchasing.

"Is the hospital superintendent such an omnipotent and expert executive that he can do without the advice of trained bureau experts, granted that he is in a position to sense and develop the hospital needs and special wants?" Dr. Babcock asked.

"After twenty years of hospital buying," he asserted, "We are sure that great advantage can accrue to the buyer who will avail himself of every assistance in a field that he is not able to cover fully as an expert."

Dr. Babcock then reviewed what his own hospital has been able to accomplish alone through the service of the Hospital Bureau of Standards and Supplies. He told of one case where he was puzzled as to where to look for the contents to refurnish several rooms that had been originally furnished in mission style fumed oak. He cited many other cases where he and others had greatly benefitted by keeping constantly in touch with the service that the bureau offers its subscribers. He outlined what might be expected from the development of the bureau and what progress was being made by it in many different lines.

Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn., and chairman of the committee on general furnishings and supplies.

No greater compliment can be paid either to the speaker or to the subject than the number and quality of discussions which the reading of a paper brings forth. Many delegates contributed their opinion regarding the advantages and disadvantages of this system of buying. Nor was the opinion of the administrative section entirely unanimous in feeling that cooperative buying could be adopted to advantage by all hospitals, irrespective of the type of organization or their geographical situation. Dr. Henry K. Mohler, medical director, Jefferson Hospital, Philadelphia, spoke rather positively in favor of the system. He stated that on the purchase of one commodity alone he had saved in excess of the amount of expenditure for his membership in the New York Bureau of Standards and Supplies.

Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, and Mr. Guy J. Clarke of the Cleveland Hospital Council also favored the principle of cooperative buying, with a few reservations. It appeared to be the opinion of other speakers that at least 60 per cent of all articles required for the hospital could be advantageously purchased in this manner. The chairman of the section suggested that if cooperative buying is to be made practical standards of supplies must be more carefully worked out in order to secure intelligent competitive bidding. He also said that any suggestion of paternalism on the part of the purchasing bureau, in so far as the type or quantity of supplies are concerned, would prove a hindrance to the development of the practice.

Mr. Jason D. Byers, George Washington University Hospital, Washington, D. C., advanced the query as to whether because of community support through drives or by taxation, the hospital had an obligation to buy of local merchants.

Dr. Babcock in summing up at the conclusion of the discussion stated that in Detroit, although the city is 600 miles from New York, he experienced no difficulty in purchasing as promptly and as intelligently as if his buying were done much nearer home.

In discussing the topic, "Reception of Patients in a Hospital," Ingersoll Bowditch, president, Sharon Sanitarium, Sharon, Mass., recited several personal experiences to illustrate what an unfavorable impression is often created on patients by officials who meet them at the door and treat them as a "case" throughout their stay in the hospital.

He suggested that in order to overcome this obstacle hospitals would do well to employ a person whose duty it is to receive patients in a cordial manner, escort them to their rooms and to see that personal interest is taken in them in such matters as stationery and reading matter, and other small attentions during their stay.

He also discussed the reception of patients' relatives who are too often treated in a cold, unsympathetic manner and do not receive the consideration to which they are entitled. Such an attitude reacts unfavorably toward the hospital.

In discussing the subject of the ownership of case records, Elmer E. Matthews, superintendent, Wilkes-Barre City Hospital, Wilkes-Barre, Pa., firmly established the idea that the case records are the property of the hospital but that if the hospital, in cooperation with the attending physician, should feel that some part of this record would be of value to the patient, there is no reason why he or she should not be given this information.

The speaker stressed three points about records, first, that they are primarily charts for the patient, secondly, information for the doctor, and finally, a contribution to medical science.

That unless records are used to improve the type of medical service in the hospital, they are utterly useless, was the opinion expressed by S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., in discussing the subject of case records. Mr. Davidson stated definitely that a record means little or nothing in itself if boards of trustees do not take a firm stand and, if necessary, compel practitioners to make such use of the records as will bring about a constantly improving service.

In order to do this physicians must write the records themselves, keep progress notes, made resumés, and discuss to the last detail all cases of non-improvements, deaths, or any cases that have come back to the hospital a second or third time because of lack of proper care and follow-up. Too many hospitals, he said, have the reputation of keeping first class records when they are doing nothing more than just keeping records.

"Hospital Charges to Members of Staff and Personnel," was the topic discussed by George W. Wilson, superintendent, Hamot Hospital, Erie, Pa., who made a report on the answers to the questionnaires on this topic sent to approximately 175 hospitals of the United States and Canada. The replies showed a wide divergence of custom in this respect in the 127 hospitals answering the questionnaire. Thirty-nine and one-half per cent of those replying stated that staff members receive personal care

without charge, while the other sixty and one-half per cent make charges. To the question, "Do families of staff members receive care without charge?" seventy-five and one-half per cent of the hospitals made a negative reply, while twenty-four and one-half per cent were in the affirmative. The question, "Is any concession made when staff members receive care?" revealed that sixty out of the seventy-seven hospitals which do not render free care to staff members make at least some concession, some giving a discount ranging from ten to sixty-six and two-thirds per cent. The majority give from twenty to thirty-three and one-third per cent.

Relative to the provision made for nurses who are alumnæ of the hospital, ten per cent reported endowed rooms, twenty hospitals reported that free care is given where endowed rooms are not provided, while forty-five hospitals grant concessions ranging from ten to fifty per cent, while five of the total make no concession.

Favors Free Service to Staff Members

In discussing the replies, Mr. Wilson expressed himself in favor of extending free service to members of the staff but not to members of their families. In regard to physicians other than staff members, he said, "With physicians who have no hospital connection it would appear that a policy for the institution to obligate itself to render free service in such instances, to perhaps several hundred physicians, is an uncalled-for obligation."

On the other hand, he said that the custom of rendering free service to staff members at Hamot Hospital had been criticized by contributors of the community chest who feel that it is unfair to ask the community's citizens to make up deficits incurred through providing free service to prosperous physicians of the community.

Static In Operating Room

At one of the round table conferences Dr. E. I. McKesson, anesthetist, Toledo, Ohio, discussed the topic of how we can eliminate static from the operating room to avoid accidents with anesthetics. He pointed out that the simplest method of preventing static sparks is to keep the objects concerned in the administration of combustible mixtures in contact—the patient, the anesthetist and the inhaler.

Dr. McKesson said, in part: "An effort has been made at one hospital to make errors impossible by grounding a mosaic floor, consisting of alternate blocks of tile and bronze, in one or two rooms and a solid metal floor in another. That is, when one steps upon this floor the charge on the body flows through a thick wire to the ground. The operating table, apparatus, instruments, anesthetist and surgeons are thus grounded or their charges neutralized.

There are three possible slips in technique that still require attention even in this system: (1) The patient must be rounded to the table by actually attaching some conductor to the skin of his body, such as a wire or chain. (2) The anesthetist's shoes must be conductors and not rubber or dry leather. (3) Grounding, particularly of the patient, anesthetist and inhaler or apparatus, must be done before starting to administer a combustible mixture."

In conclusion Dr. McKesson mentioned two systems of preventing static sparks: (1) Neutralize differences of electrical potentials by grounding everybody and everything coming into contact with and including the patient before beginning the administration of a combustible anesthetic; or, contact the anesthetist, inhaler and the patient's face before turning the combustible anesthetic into the inhaler and maintain this contact throughout anesthesia. (2) Administer only nitrous oxide oxygen in the presence of known sources of ignition, such as cauteries, x-ray and fulguration apparatus and open fires.

Matthew Foley of *Hospital Management* told the hospital executives that they should tell the public what they are doing and urged the superintendents to cooperate closer with the newspapers of their cities. He told of some of the work that was being accomplished where hospital superintendents knew publicity. He stressed the importance of "telling the public" in the furtherance of community good will toward the institution.

LIBRARY AND SERVICE BUREAU MAKES STEADY PROGRESS

The report of the Hospital Library and Service Bureau was read by Donelda R. Hamlin, director, Chicago, who summarized the accomplishments of the bureau during the past year and the purposes and objectives of the service.

Among the activities of the past year was an informal study of the educational facilities for colored nurses and their use in public health and hospital nursing. The study included all accredited schools of nursing, a total of 1696. Of this number only fifty-four schools reported the admission of colored students, sixty-six used them on their regular nursing staff and sixty used them as specials largely for colored patients.

Extensive service, especially in the form of package libraries and bibliographies, was given to the college of hospital administration, Marquette University, Milwaukee, Wis., both to the faculty and students. Nearly two hundred package libraries were furnished for reference work during the course in nursing education given at the University of Florida and at the University of Chicago.

An extensive bibliography on hospital executives, their education, duties, responsibilities, was recently completed by the bureau. At the request of the A.H.A. committee on training of hospital executives the bureau permitted its publication as a part of the report of that committee.

A special exhibit of general hospitals recently constructed has just been assembled by the bureau, and many new plans have also been added to the educational exhibit of floor plans which now contains plans of over eight hundred institutions. Miss Hamlin also included in her report a brief description of the organization and operation of the bureau and its various types of service available to all persons engaged in hospital work.

The report of the Hospital Library and Service Bureau was discussed by Dr. L. H. Burlingham who felt that the work of the library was so well known to most hospitals that its services spoke for themselves. The discussion also brought out the value of the library's literature not only to the hospitals themselves but to the surveys that are being made in various communities.

After Florence Nightingale had returned from the Crimea, fuller of honors than any soldier who had fought there, she was asked to help clean up London, whose hospitals at the time were the breeding ground of infections of all kinds, including gangrene. She accepted the call and demanded "soap, water, and sunshine." We have followed many false gods of cleanliness since that day—disinfectants and bactericides whose name is legion—and have now found our way back again to Florence Nightingale's shrine of health, "soap, water, and sunshine."

One of the largest hospitals of its times was founded by Bishop Masona in Merida, Spain, about the year 580.

STEPS TAKEN IN EDUCATIONAL TRAINING FOR EXECUTIVES

Reported by A. C. Bachmeyer, M.D., Superintendent,
Cincinnati General Hospital, Cincinnati

THE hospital's part in education and training was emphasized by the presentation of several interesting papers. This function of the hospital is being recognized to a greater extent every year. The need for definite programs providing for the education and training of administrators has been recognized for a number of years. Definite progress in establishing such programs was made this year.

While the need for the training of hospital administrators can be measured the demand for such training has been sporadic and rather vague. The appointment of a committee with definite functions looking to the development of this field will do much toward the final solution of the problem. It is hoped that through publicity the attention of qualified individuals may be attracted to the field of hospital administration as one worthy of selection for their lifelong effort, and that recruits may be had for training courses. It is also hoped that a number of courses of short duration may be arranged for the benefit of executives and subordinates now engaged in hospital work.

Dr. M. T. MacEachern, director of hospital activities, American College of Surgeons, Chicago, chairman of the committee on training of hospital executives, presented the report of his committee.

The need for training courses for hospital executives was clearly demonstrated in the first section of the report.

It was pointed out that the 8,000 hospitals in the United States and Canada, with a daily average of 700,000 patients, do not meet the need for hospital care of the sick, as has been shown by recent surveys, and it is therefore reasonable to assume that the building of new hospitals will continue at an increasing rate of speed. The report emphasized the fact that hospitals have rapidly developed into a highly complex specialty requiring a staff with superior intelligence, skill and training, for the hospital not only cares for the sick but has an educational function and is a factor in the community for preserving health, through its out-patient department, social service and the respect the community has for the hospital.

There is a shortage of capable men and women to manage institutions, for the training and development of such executives has not kept pace with the development of the hospital business. There is a demand for men and women trained in the professional, technical and business angles of the work; their qualifications should include a knowledge of institutional management, scientific technique, minimum standards for hospital service, community welfare and public health activities. Three groups need this training; superintendents now holding positions but desiring to increase their usefulness; assistant superintendents aspiring to independent positions and those who are desirous of entering the field and are willing to devote time and money to meet the requirements of the curriculum as outlined by the educational board of the American Hospital Association.

Three representatives of medical colleges who attended the conference. (Left to right) Dr. L. S. Schmitt, superintendent, University of California Hospital, and acting dean, medical college, University of California, Berkeley; Dr. Herman Weiskotten, of the medical college, Syracuse University, Syracuse, N. Y.; and Dr. Maurice H. Rees, of the faculty of the University of Colorado, medical college, Boulder.

(Left to right) James U. Norris, superintendent, Woman's Hospital of the State of New York, New York; Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati; Dr. N. P. Colwell, Council on Medical Education and Hospitals of the American Medical Association, Chicago; and Dr. Carlisle S. Lents, University Hospital, Atlanta, Ga.

In opening the discussion on the report Edward A. Fitzpatrick, educational director, college of hospital administration, Marquette University, Milwaukee, Wis., said that the report dealt comprehensively with the problems of training executives and marked a distinct advance in the treatment of the subject.

The first section of the report states distinctly the need

for training in the paragraph: "The existing need then, is first, for the training of superintendents now holding positions but desiring to increase their usefulness by additional knowledge of those phases of management which were not previously acquired, and second, the more adequate training of assistant superintendents aspiring to independent positions, and finally, a complete course for those who are desirous of entering the field and who are willing to devote time and money necessary to meet the requirements of the curriculum as outlined by the American Hospital Association."

Present Centers for Training

He said that the second part of the report reviewed comprehensively the entire discussion of the problem of training hospital executives by E. S. Gilmore, Dr. C. G. Parnall, Dr. S. S. Goldwater, and other prominent hospital administrators. It also reviews the plans that had been announced at Yale University and at Cincinnati University and calls attention to the short courses at Temple University, Philadelphia, and at New York University, New York. It indicates specifically the nature of the demand for nurses, physicians and laymen and discusses the problem of training of each of these groups, pointing out the need for special courses, for an undergraduate course in various phases of hospital administration and for graduate study. It outlines curricula for each of these groups and indicates very specifically the nature and the content of each course. The basis of these curricula is the careful experimental work done at Marquette University during the past two years in developing its courses for the training of hospital executives.

It recommends a period of one year internship in hospital administration after the completion of the courses, and points out the educational principles which must underlie the development of these curricula.

The third section of the report deals with the problems of ways and means and provides definitely for cooperation of the association with universities training hospital executives and for an organization of the members of the association in local centers to provide observation courses similar to the work that the American College of Surgeons now does in Chicago for the visiting surgeons. This organized knowledge of facilities in the various large hospital centers of the country also furnishes a means to provide further practical work for the students in hospital administration.

The need for such courses of training was discussed by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, who showed the growing necessity of special training for hospital executives, since the administration of hospitals is steadily becoming more complex and highly specialized.

The need for such training was also discussed by Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, who said that the need was great, since the history of hospitals had been a history of errors made because of lack of knowledge and training on the part of superintendents and executives, and that schooling was needed in order that future directors could grasp the objectives of hospital service and their responsibility in medical work.

In discussing the subject from a general standpoint Dr. Charles C. Burlingame, executive officer, Joint Administrative Board, New York, said, that a definite step in training executives would take hospital administration out of the class of a highly paid secretary and put it on a plane with that of a profession or professional business. He said that he was particularly interested in the promotion of the work of training as a means of educating the boards of eleemosynary institutions who need to be brought to a realization that the position of administrator is of sufficient importance to warrant specialized training. To his mind one of the great things that will come out of the movement will be the development of standards for such boards. In regard to the working out of curricula he directed attention to the work as it is being developed at Marquette University, Milwaukee, with its liaison of hospitals, where a uniform type of training and workmanship is being accomplished, as a great constructive force in educating present administrators and executives.

The curricula for a course or courses for the training of hospital executives was dealt with in the second and main section of the committee report.

Daniel D. Test, A.H.A., trustee and superintendent, Pennsylvania Hospital, Philadelphia.

The first significant step in the effort to provide facilities for the training of hospital executives was the report of the committee on the training of hospital executives financed by the Rockefeller Foundation and published in 1922, and the major conclusions and recommendations of the report are summarized in the A.H.A. Committee's report, which also reviews the work done by the A.H.A. committee in 1924, and the various efforts that have been made to provide university training in hospital administration on a professional basis.

Special Courses Offered

At Teachers' College, Columbia University, New York, the work in hospital administration is an incidental part of the work of the training of administration. At Yale University and the University of Cincinnati courses were announced and planned but no students presented themselves and nothing came of the experiments. The report emphasizes the fact that the need is for the stimulation of intelligent experimentation in all kinds of courses to clarify the field and set up definiteness of objective and procedure. A college of hospital administration was established in 1924 at Marquette University, Milwaukee, Wis., and the plan of study adopted there is outlined in the report. The president of the university felt that the whole problem must be continuously studied and its direction guided in accordance with the best thought and practice in the field of professional education, and consequently an educational director was appointed to keep the educational considerations uppermost.

The nature of the interest (1) in a trained hospital personnel and (2) in securing training on the part of the hospital personnel itself indicates the nature of the de-

mand that might be developed by intelligent cooperative effort on the part of the hospital associations, hospital administrators and the universities engaged in training hospital personnel. A major service to the hospital field can be rendered by this association by a well conceived and well conducted recruiting campaign among college students and an educational campaign among present personnel to secure adequate training for a new profession offering at least a fair compensation (and in some cases as high as $18,000 a year) and the durable satisfaction of life in performing on a wholesale scale, if you permit the expression, one of the great corporeal works of mercy—the care of the sick.

An analysis of the correspondence of some hospital executives and the hospital association indicates that the demand and interest come from three sources.

(1) a. Nurses who desired to enter the hospital executive positions in schools of nursing or in supervisory or other positions.
b. Nurses in charge of small hospitals who wished to be better trained for their work or desired to be prepared for larger opportunity.

(2) a. Laymen working in some aspect of hospital (e.g. as business manager or bookkeeper or engineer) who desired to be prepared for the superintendency. In some cases they had already been designated for the position, but they desired training only for a short period.
b. Laymen in charge of small hospitals who wished to be prepared for larger opportunity, or to better serve in their present capacity.

(3) a. Doctors who desired to enter hospital administrative service.
b. Doctors who wish to learn about their present job or to be prepared for larger opportunity.

Demand Is for Short Courses

The original demand of hospital people is almost always for short practical courses. This comes about largely from too narrow a conception of the social, health and educational opportunity which the hospital offers, and also from a limited knowledge of the rich fields of public health, and of the sciences of chemistry, bacteriology, psychology, and preventive medicine, and of the new sciences of business organization and administration in their relations to hospital service. It may be said that almost universally as this vista is presented, these people are perfectly willing to consider longer training. The need is for an educational program.

The relative value of men and women as hospital administrators is discussed in the report and it is pointed out that for the salaries paid for many hospital superintendencies more intelligence and higher efficiency can be secured in women than in men, and that in many spheres women have extraordinary executive capacity in handling intricate problems and mixed and numerous personnel. Undoubtedly for a long time to come nurses will be appointed to the superintendency in the small hospitals and a college of hospital administration must settle the following questions related to the curriculum:

(1) What credit will be given to the nurse's training, assuming high school graduation?

(2) Shall the training be on an undergraduate basis, i.e., built upon the nurse's training combined with such academic work as may be prescribed?

(3) Shall it be given on a graduate basis, i.e., wait until the nurse takes at least the equivalent of two years' additional academic training. Occasionally a case will present itself where the applicant, though a nurse, or a laboratory technician, or a dietitian, has not the necessary high school credits. This type of applicant is frequently over 21 years of age and may be admitted to the university as an adult special. The new question raised by this type of case, and by administrators who cannot spend the time for a full course, is:

Shall the university organize a one year or two year course leading not to a degree, but to a certificate of proficiency in hospital administration for such persons?

The question of the doctor versus the layman in hospital administration is considered in the report and suggestions put forward for meeting their respective needs for training. Training for hospital executives other than the superintendent is also touched upon and suggested curricula outlined for the two most important of these—the business manager and the superintendent of nurses.

The nature of the demand for training in hospital administration indicates the desirability of organizing three different types of courses, namely:

(1) Courses for people of maturity and experience with limited education, and for people of maturity and successful experience who may or may not have at least high school education or even college education but whose time is limited.

(2) Courses for young people who might early be recruited into the profession and for nurses or other hospital personnel who are high school graduates, and who after practical experience desire to open up to themselves the opportunities of a career in hospital administration and want to be prepared for it when it comes.

(3) Courses (a) for college graduates who want to combine a practical and theoretical training in the field of hospital administration in order to enter as superintendents of small hospitals or to take lower administrative posts in the larger hospitals, (b) for practicing physicians who desire to secure training in hospital administration.

Suggested Courses Well Outlined

The report gives a detailed description of suggested courses in hospital administration and lays down as follows the educational principles underlying the curricula:

(1) The raw material of the curriculum is as ordinarily expressed, the contemporary social life. For the hospital administrator this would naturally be the public health aspects of social life, the caring for the sick, the hospital personnel, the hospital services, equipment, purposes and such related knowledge as will help interpret present function.

(2) The material to be selected will be affected by the purpose of the education to be given. The education in this case is vocational or professional, i.e., to develop competent administrators of hospitals who have a broad conception of the public health movement and the hospital's relation to it, who understand the general and sociological relation of the hospitals, and who understand the local development and the tendencies of the institution as affected by all the influence of modern life in an actual community as well as the skilled services of hospital personnel, its training, coordinating departments, etc.

(3) The material to be selected must be determined by the mental ability of the learner. The material must be adjusted to the capacity of the learner. It must be psychologized. The arrangement of material on the basis of logical relationships without reference to the processes of the learning mind will lead to failure here as it has in every other form of educational endeavor.

(4) Closely related, but nevertheless needed to be stated separately for emphasis, is the requirement that

the subject matter of instruction must be selected with reference to the *previous experience* as well as the intellectual capacity of the student. Lacking this relationship there will be no connection between the old and the new, no means of bringing the new into relation with the old for interpretation or use of the new or reinforcement of the old.

(5) What shall be taught will naturally be limited by the amount of time available to present, consider and digest material. Full, rounded training may be possible in four years which is not possible in one year for the same person. Or what is possible in one year may be impossible in a summer school or a couple of weeks' course. Time will be here in many cases "of the essence." The question of relative importance must be settled.

(6) Emphasis may also be given to this point by pointing out that in class instruction the material to be selected must take into account the wide range of abilities existing in any group of persons such as make up a convention of superintendents or a class in a university.

(7) The material must naturally be arranged in a progressive order. It must develop wider range of subject matter, more complex, and represent increasing insight and higher skill.

Ways and Means Much Discussed

The discussion of ways and means of training hospital executives was taken up from three different angles in the report of the sub-committee having this topic under consideration. First was suggested the university training which would give the future executive a thorough basic education and an extended course in the theory and practice of all phases of institution administration as well as advanced courses in public health and social sciences. This training should be obtained in close proximity to a medical school and hospital so that the student, if not medically trained, might absorb professional ethics and gain a store of essential medical knowledge. The requirements for admission to this course would be such as to exclude those not possessing the fundamental characteristics essential to a good executive. Credits would be given so that graduates in medicine would be encouraged to enter the field.

For those now occupying executive positions who wish to broaden their knowledge of hospital administration but who cannot afford more than a month away from their hospitals, it was suggested that short courses be conducted in large cities where a local board of hospital executives can be formed under the auspices of the central board of the A.H.A. The curriculum would offer practical training in clinical record work, purchasing methods, clinical technic, food service, accounting, training school procedures and the multitudinous phases of hospital work a knowledge of which can best be gained by personal visitation to hospitals where the particular phase is efficiently conducted. A small fee would be charged for these courses to make them self-supporting.

Special arrangements would be made for students in Chicago, where a curriculum would be arranged to include lectures, classes and personal visitation to hospitals that are so developed as to serve as models for demonstration.

A third suggested means of training was an observation course for assistant superintendents. This would be an extended course similar to the one already mentioned and would be open to those holding assistantships in good hospitals and recommended by their superiors. The course would last six months when a practical examination would be given, leading to a certificate of efficiency. Candidates would then be referred to the hospital personnel bureau of the A.H.A. for placement without charge. A fee to cover expenses of the course would be charged.

The report referred to courses for hospital executives now in operation in different cities, and pointed out that all courses should be standardized to meet certain fundamental requirements that have been generally agreed upon as best adapted to prepare an individual for the work of hospital administration.

It is hoped that financial assistance for the support of the program may be forthcoming from the Foundations interested in medical education.

A resolution was passed recommending that the report of the committee on training of hospital executives be approved and accepted and that a committee be appointed to function as recommended in the report.

In discussing the ways and means by which the association can promote these courses, Dr. A. C. Bachmeyer praised the committee for the tremendous amount of work it had accomplished in preparing such elaborate curricula for university courses for the various types of people desiring to go into hospital administrative work. He advocated that the central committee make a thorough job analysis, provide for observation course facilities in large centers, that it conduct a recruiting campaign to picture what hospital education really is, and plan for the ways and means of financing such education.

The relation that the medical college and the hospital bear to each other was discussed in the paper of Dr. Stuart Graves, University of Louisville, Louisville, Ky. Many had hoped that Dr. Graves' paper would discuss the general question but it dealt rather with the existing situation at the University of Louisville and the Louisville City Hospital, portraying a working arrangement that is proving satisfactory but which lacks legal sanction. The Louisville situation emphasizes the fact that local conditions must always be taken into consideration in the solution of individual problems and that many times such individual solutions of a problem do not have a general application. Relations between medical colleges and hospitals must always be of the most intimate nature. There must be recognition, however, upon the part of the faculty of the college of medicine that the hospital's paramount function is service to the patient and that medical education while very important must always be a secondary consideration in the hospital. On the other hand, there should be understanding on the part of hospitals that every possible facility should be provided for the proper conduct of instruction for the medical student.

While the education of the undergraduate medical student is a function exercised by only a comparatively small number of hospitals a large majority of all hospitals are interested in postgraduate instruction, and particularly in that of the recent graduate.

Relation of Hospital to Community

In his paper entitled "The Relationship Between the Teaching Hospital and the Medical School" Dr. Graves paid tribute to the consistant cooperation of the Board of Public Safety of Louisville in coordinating the work of the University of Louisville School of Medicine and the Louisville City Hospital. The relationship between these two municipal institutions is so close that they might be regarded as one; this, Dr. Graves believes, is unparalleled among the medical schools of the country.

No legal foundation is back of the union between these two and the relationship may be terminated at the will of either. Nevertheless, they are interdependent and their motto is and must be service to each other.

The University of Louisville is the oldest municipal

university in the United States, Dr. Graves stated, and its school of medicine has developed in an unbroken line. Its approximate enrollment today is 275 students and applications greatly outnumber vacancies. It has established high academic, moral and research standards.

Louisville City Hospital was built twelve years ago and was designed for a teaching hospital. No written agreement governed the relationship between the medical school and the hospital until 1922 when certain principles that should govern the relations of the two were reduced to writing and these govern the relationship today.

All legal authority for the working of these two institutions resides in the Board of Public Safety, a board of three men. Under this board is the hospital superintendent, who although officially the head of the hospital, superintends the business side only, leaving the professional side to the university. Appointments to the hospital visiting staff are made by the board of Public Safety on the nomination of the dean of the medical school, after the approval of the hospital staff executive committee. The house staff is also appointed by the board on the nomination of the dean. In practice the actual selections so far as local graduates are concerned, are made by the teachers most familiar with the students' work and thus in a position to recommend them to the dean.

The hospital staff executive committee is the authoratative body in the hospital under the Board of Safety so far as professional work is concerned. This committee consists of the superintendent, the dean, the executive of the medical service, the executive of the surgical service, the director of the department of pathology, bacteriology and serology and one member of the clinical staff. This committee must approve all visiting staff nominations. Monthly conferences are held for the discussion of hospital problems.

The organization and grouping of the professional services in the hospital, the conduct of such services and assignment of cases are under the control of the staff executive and the dean of the medical school. In practice this control is exercised after consultation with university and hospital authorities and after consultation with heads of the departments.

The staff executive, who acts as medical superintendent, is appointed by the Board of Public Safety on recommendation of the dean.

The heads of the semi-professional services, such as the superintendent of nurses, the director of the social service department, the director of occupational therapy, are appointed by the Board of Public Safety. For such appointments the staff executive may submit to the board nominations approved by the hospital staff executive committee. In all matters relating to the care of patients such appointees are responsible to the staff executive.

Relationship Not a General One

In discussing Dr. Graves' paper Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, Md., emphasized the fact that the relationship dealt with in the paper was not the general relationship between the teaching hospital and the medical school but the particular relationship between Louisville City Hospital and the medical school of the University of Louisville, which, he felt, was the result of local conditions and influences. This could not, therefore, be regarded as typical, first because the institutions described were municipal institutions and most teaching hospitals are either private hospitals free from municipal control or are strictly university hospitals, and second because so much that is valuable is by the arrangement described left to chance and the altered conditions that often result from changes in the political administration of cities.

Dr. Smith is in sympathy with Dr. Graves in feeling that a spirit of service to each other should prevail between the medical school and the hospital. The medical school cannot exist without the hospital and although the hospital can exist without the medical school its possibilities are greatly enriched by obtaining the services of men who keep abreast of all that is new and worth while, as men must do who teach and carry on investigative work.

Advocated Printing Intern Report

The report of the committee on interns submitted at this year's convention should be studied only in connection with the report which that committee presented last year. The committee expressed the hope that the board of trustees of the association would find sufficient funds to permit of the publication of the two reports in a single document.

Hospitals having intern staffs and deans of medical colleges should carefully study the report. Institutions contemplating either the introduction of intern service or the reorganization of their present methods will have available (upon request) the assistance of the committee which was appointed for that purpose.

The report was submitted by Dr. Nathaniel W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., chairman of the committee. It remains substantially as published in 1924, only minor additions and corrections having been made in it. These changes incorporate suggestions made in replies received to a letter sent out by the committee to forty-eight hospitals and medical schools in the United States and Canada. The most important of these is contained in an additional recommendation which reads as follows: "That the American Hospital Association establish an advisory committee on interns, this committee, upon request, to advise and assist hospitals in selecting that type of intern organization best suited to their needs."

The amended report was submitted for action.

The discussion of the report of the intern committee centered around the question of whether hospitals should be permitted to pay interns for their services. A number of superintendents said that they found it advisable to give interns a small financial remuneration, since such contributed a great deal to their morale, in their need of financial aid as the result of the large expenditure in their medical education.

In reply to the discussion Dr. Faxon, representing the intern committee, said that it was unwise to pay interns as a general practice because the intern year should be looked upon as an educational year, and that in no sense should interns be encouraged to expect remuneration for their services. In discussing this subject Dr. S. S. Goldwater said that paying interns was a matter of expediency rather than of principle with a number of hospitals and that if the practice of paying interns were to spread it would result in a rivalry between hospitals and an uneven distribution of interns.

The points were also made that the intern year should consist of apprenticeship in every branch of medicine and that specializing or special elective service should be done later, and that under no consideration should an intern accept tips or money from staff physicians.

The question of the "Practicability of Training Male Nurses" was discussed at a round table conference by Dr. George O'Hanlon, superintendent, Bellevue and Allied Hospitals, New York.

HOSPITAL TRUSTEES HOLD PROFITABLE SESSION WITH ROUND TABLE QUESTIONS

By J. D. Burge, President, Board of Trustees,
John N. Norton Memorial Infirmary, Louisville

THAT the trustees of the average hospital are taking a more vital interest in hospitals was proved by the meeting held during the sessions of the convention at Louisville.

The attendance at the trustees section meeting was not as large as was anticipated but the interest shown in the round table was keen and the enthusiasm shown generally in the entire convention was much more marked than at other annual meetings.

The first question that was submitted for discussion was the relation of the superintendent to the board of trustees. The ensuing remarks brought forth the fact that it was extremely difficult to get trustees to attend the monthly meetings. It had been found that it was better to use executive committees and other subcommittees to form the contact between the members of the board and the superintendent. It was also pointed out that efforts should be made to have the members meet periodically.

Father Maurice F. Griffin, St. Elizabeth's Hospital, Youngstown, Ohio, trustee of the association.

To the question whether a trustee should profit financially from a trust fund, the unanimous opinion was that he shouldn't. It was considered obvious that a trustee should in no way profit and there was but little discussion on this question.

"What Rules Should Govern the Investment of Trust Funds" found the trustees fairly well agreed on the two prime considerations of safety and interest. The investment in real estate was frowned upon by most of those entering into the discussion.

The Hospital Library and Service Bureau was mentioned in the interesting discussion on the question, "Is an Occasional Survey of a Hospital by an Outside Consultant Desirable?" It was pointed out that such a survey was not only desirable but in many cases necessary and that much additional value could be obtained by consulting the Hospital Library and Service Bureau more frequently.

There was little doubt in the minds of the trustees that osteopaths, chiropractors and other cults should be excluded from practicing in the hospital. While there was some discussion on the question, most of it was to the point that only sciences of proved merit should be allowed and that neither osteopathy nor chiropractic had demonstrated their actual value.

There are decided disadvantages in having members of the professional staff on the governing board according to the consensus of opinion of trustees, and it was agreed that boards function more uniformly and with less friction if they are made up entirely of men other than those on the house or visiting staff.

"Let the superintendent alone" was the trite manner in which the question, "To What Extent Should Members of the Governing Body Assume Administrative Functions in a Hospital with a Capable Superintendent?" was answered by the trustees. That a superintendent is often hampered by members of the board, who may be well-meaning but not conversant with all of the hospital problems, was brought out and it was generally agreed that it was the duty of the trustees to secure a capable superintendent in whom they had confidence and then allow him to work out his problems in his own way, being guided and advised by the board only in a general manner and in regard to policy and finances but not to specific problems too detailed for consideration by the trustees.

As a preliminary to discussing "What Basic Qualifications Should be Considered in Selecting Trustees," Mr. John M. Smith, director, Hahnemann Hospital, Philadelphia, outlined the duties of the board of trustees by quoting as follows from the report of the trustee section of the 1924 conference of the association:

(1) To determine the policies of the institution with relation to meeting community needs.

(2) To see that proper professional standards are maintained in the care of the sick.

(3) To coordinate the professional interests of the hospital with the administrative, financial and community needs.

(4) To direct the administrative personnel of the hospital in order to carry out the above policies.

(5) Adequate financing, both as to securing sufficient income and as to enforcing businesslike control of expenditure.

"Members of a board of trustees," said Mr. Smith, "must be men of high standing who have good judgment, who are farsighted, and who represent the various important groups, such as social, religious and labor organizations. A board should have in its membership an able lawyer and two conservative investment experts. It is recognized that the superintendent should sit in all board and committee meetings either as an ex-officio member or as secretary. His expert knowledge will be very valuable and will make for a smooth running organization. No physician who has the privilege of diagnosing or treating patients in the hospital should ever be a member of the governing body as jealousy, distrust and friction are very likely to be the result. It has not always proved advisable to have architects, engineers and other similar professional men on boards."

Mr. Smith stressed the point that board members should be men able and willing to give generous financial support to the hospital or in a position to secure it from others. If they have ability to finance the institution and are also representative citizens it is generally found that they can meet all their other responsibilities.

Many informal topics were discussed by the trustees.

INCREASED EFFICIENCY IS THE KEYNOTE OF SMALL HOSPITAL SECTION

Reported by Margaret J. Robinson, R.N., Superintendent,
Montefiore Hospital, Pittsburgh

A SMALL community hospital when properly correlated with other public health social service activities, very evidently is the public health center of a locality.

If we wish to bring it to its highest standard of usefulness, however, serious questions come up for discussion. Can it reach these standards without proper education and supervision? May it not become a prey to uncertain local influences? May it not become too much of a camping ground for the unsupervised work of the uneducated physician? And may it not, unless carefully guarded, vegetate within its own ideals of things and lose its vision unless it has proper and frequent contacts with bigger hospitals and bigger minds?

It is possible that at some future time we may work out some scheme whereby the small community hospital may keep its own individuality and its own autonomy, and still have enough educational contact to keep it from rust and abuse of privilege. There must be some happy medium for these hospitals between the place where they become swallowed up and simply used for the advantage of some greater institution, and the other extreme, where they are liable to be failures because they lack the contact with the educational and economic experience of better and older hospitals.

Community Aspects

Esther J. Tinsley, superintendent, Pittston Hospital, Pittston, Pa., in presenting the paper "Community Aspect of the Small Hospital," gave a vision of what the contacts of the small hospital should be with its community, rather than the history of the actualities involved. She gave as a first and fundamental principle that such a hospital should provide adequately for the needs of the immediate community in giving medical care and social service to the sick, and that its ideals would be shown by its policies in the development of the medical and nursing professions. She feels that each community has definite expectations of the community hospital; of what it shall produce in building and equipment and service to the sick and in the work of its staff.

According to our most recently developed standards the small community hospital must not only meet the requirements in training school organization and the better education of nurses, but in its standards of medical education and in producing all facilities for group diagnosis in the way of radiographic and pathological laboratories now deemed essential.

She stressed the fact that the size of the hospital should not prevent the necessity of its meeting the above standards; that although they did not have to be met in such a large measure they should be met completely in all departments.

Advantages of Small Hospitals

Miss Tinsley mentioned the strength of the human element in the small hospital and the atmosphere of family life, which, if fostered made for better understanding and better care of the patient.

Perhaps this was the most valuable point of this paper: that the superintendents of small community hospitals and their boards of trustees should take more time and give more thought to educating their surrounding community, and explaining to civic and social, medical and nursing bodies and various clubs, what the ideals of the small community hospitals are and the great power possessed by these hospitals to become community health centers and the center of education in the community's public health program.

Miss Tinsley stated that in her opinion it was perfectly legitimate to use the publicity of the newspapers to make an appeal for funds to build up the hospital, and it was also of value to talk at times to students of the nearby colleges and high schools, giving them higher ideals of community hospital value. She also mentioned the necessity of direct and friendly contacts of the community hospitals with the social agencies and the desirability of giving the privileges of the hospital's educational facilities

Two denominational hospital workers: (left) Hulda Hulquist and Ellen Christenson, Lutheran Trinity Hospital, Kansas City, Mo.; and four Canadian delegates: (left to right) Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg; Dr. L. C. Gilday, Western Hospital, Montreal; Dr. G. S. Wilhaw, Children's Hospital, Winnipeg; and Dr. F. C. Bell, Vancouver General Hospital, Vancouver, B. C.

Over fifty Catholic Sisters from different parts of the United States and Canada attended the convention. They represented many different Orders.

to school physicians and nurses and workers of other correlated agencies.

Much water will flow under the bridges before the extremists in social service and the extremists in hospital economics will decide the dividing line between the social case record which proves the demand that the patient must be cared for "willy nilly"—whether he is a proper case for hospital admittance and social assistance; whether he is a legitimate case able to pay his way; or whether his status should be decided upon by his need only or his need plus his economic condition.

We all grant that the financial report and the social case history are two different things. We feel, however, that they cannot be too far separated, if a clear picture of the social condition is to be produced.

B. M. Bamber and E. L. Pond, Grasslands Hospital, Valhalla, N. Y.

The findings of the social case history must govern several things: The admission of the patient to the hospital—both his social and economic adjustment—the need for his follow-up, medically and socially, and, of course, last but not least, the end result of this record shows whether he will become an asset or a liability to the community in which he lives.

Social service like all other recent developments of movements inspired by the impulse to do good, coupled with the American obsession for efficiency, has a tendency to swing its pendulum so far up the arc of its progress that it sometimes sticks in the clouds and fails to reach the ground of common sense.

Social Service Workers

We grant you again that the social service effort and the work of the worker is higher than the financial investigation, but in smaller hospitals where jobs cannot be finely divided and duties of personnel carefully card indexed, the social case history must give a picture of, first, the man himself in his physical and mental aspect, and, secondly, the picture of his family whom he has to support, his type of labor, and the amount of money he can produce from that labor in a given period of time.

Social service in its correlation with the medical work of the dispensary is a most valuable and legitimate aid to the doctor in his analysis and treatment of the patient, but it is not the whole thing; and to produce results that are worth while, the social case history must be built not only on the social need of the patient himself, and his surroundings and suggestions for his social adjustment, but with the idea that this history must fit itself to serve the medical treatment of the case.

In other words, the social case history cannot go off at a tangent and take upon itself the offices of a charity or educational organization, and forget its proper place in the general scheme, as a legitimate assistant in the treatment of disease, without bringing upon the whole movement of social service in the hospital the just criticism that it is costing a lot of overhead by tending to somebody else's knitting.

Limits of the Social Case History

Mable R. Wilson, R.N., president American Association of Hospital Social Workers, and head, social service department Children's Hospital, Boston discussed this important topic of social case records at the meeting of the small hospital section. The most salient point of her paper was the discussion it brought forth regarding the proper place of the social case history of the dispensary record. She seemed to feel that from a definite study of this point the social service departments of the larger hospitals found it more advisable to file the complete social case history of the patient in the files of the social service department, and that a summary of the history, sufficient to give to the doctor a picture of the social condition of the patient, in so far as it applied to his treatment of the case, should be recorded on the medical dispensary record of the patient. This does not apply to psychopathic cases.

A group from Memphis, Tenn. Left to right, George D. Sheats, Mrs. H. Markwell, J. T. Ward, B. Gilmore, R. G. Ramsay, Dr. George Gartley.

PROGRESS IN DISPENSARY WORK OUTLINED BY OUT-PATIENT EXECUTIVES

Reported by Michael M. Davis, Executive Secretary,
Committee on Dispensary Development, New York.

THE committee on out-patient work of the American Hospital Association staged an exhibit that was especially notable for the use of a lantern projector utilizing small portable films. The following are those who comprise the committee:

The many visitors to the committees' booth and to the adjoining booth of the committee on dispensary development of the United Hospital Fund of New York, manifested especial interest in methods of organizing new out-patient departments, working appointment systems for patients and in the study of plans for out-patient buildings. One would suppose from the attitude of the visitors that the steady growth in construction and enlargement of quarters for out-patient service that has been noted in many issues of THE MODERN HOSPITAL is continuing without abatement.

This growth in the size and in the significance of out-patient clinics is of first importance in increasing the economic effectiveness of the population and in protecting and promoting public health. It is evident that the dispensaries throughout the country are steadily becoming the center from which all hospital activities radiate. Increasing interest was also noticeable at the section meeting.

(Right) Michael M. Davis and Boris Fingerhood, superintendent, United-Isreal Zion Hospital, Brooklyn, N. Y., chairman of the out-patient section.

The meeting of the outpatient section on the opening afternoon of the convention included the report of the committee, out-standing because of its recommendation of national standards for out-patient service, for which the endorsement of the American Hospital Association is requested. The gist of the main report of the committee and its recommendations are as follows:

"Your Committee, following the usual precedent, held one meeting in the month of April at which was considered the problem presented by the section on dispensaries through the resolution of the American Hospital Association at the annual meeting in Buffalo in 1924. The resolution read as follows:

> It is the sense of the section on dispensaries that the committee on out-patient work be instructed to submit to the trustees of the American Hospital Association within three months a comprehensive report, together with definite recommendations on a minimum standard for dispensaries.
>
> These recommendations should embody details on the conduct and management of dispensaries, and especially on the following points:
>
> (1) Adequate technical equipment.
> (2) Responsibilities and duties of the senior medical staff of the hospital towards the medical work in the dispensary.
> (3) Prerequisites to the appointment of members of the medical staff of the dispensary.

"It is quite evident that volume of work done is increasing, that facilities are being increased and improved, that closer relationship between in- and out-patient services are being developed, that totally free service is decreasing, that social service is being generally recognized as a valuable asset, and that, generally, throughout the country, the needs of the ambulatory sick are being recognized and in increasing measure being provided for.

"The committee believes the time has arrived for the American Hospital Association to express in the form of a simple statement the minimum requirements of an acceptable out-patient department. It further is of the opinion that the trustees of the American Hospital Association would do well through conference and by other means to work with those organizations active in the hospital field to the end that the minimum requirements herewith submitted, as finally prepared and adopted by the American Hospital Association, be made, in so far as the out-patient department is concerned, the official statement in any plan of hospital rating.

"We cordially endorse these standards. Each one carries with it practical implications with respect to the organization, staff and equipment needed. Successful methods have been worked out, but will, of necessity, vary in detail in accordance with the conditions in each institution, so that the appropriate methods must be the subject of inquiry and study by the authorities of each institution.

"Your committee after serious consideration of the entire problem of the presentation of a statement of standards submits that:

"As the American Hospital Association for many years has recognized that the advance of medical knowledge and the changing character of medical practice is demanding an ever-increasing elaboration of services that will provide for the care and instruction of the ambulatory patient; and

"As the out-patient department or dispensary should not only provide such diagnostic, therapeutic and informational service for the patient but in addition should take its proper and important part in the study of the cause and treatment of disease and provide educational facilities for those concerned with the care of the sick and the promotion of health; therefore

"In order to function as an integral part of the community health program and reach its highest point of effectiveness in service to patient, physician and hospital an out-patient department or dispensary should:

I. Be a part of or closely affiliated with a hospital in order that continuity of medical care may be assured by provision of bed facilities and that continuity of professional service be provided in so far as possible by unification of staff and administrative organization.

II. Provide facilities for maintaining records (adequate as to content and easy of access), laboratory service (sufficient in amount and variety) and space for clinic quarters (proper in size, arrangement and equipment).

III. Have a medical staff to which the minimum qualifications for appointment is made on the basis of professional qualification requiring as a minimum that the physician be a graduate of a reputable medical school, have served an internship, hold a license to practice in the state and maintain membership in the medical society of the state in which the insti-

tution is located; and also in the county society.

IV. Maintain a non-medical staff sufficient in numerical strength and diversity of training to assure the essential nursing, social and clerical service that will enable the physicians to provide medical care commensurate with the needs of the patient and in accord with the modern concept of professional procedure.

V. Arrange for review of the medical work done by periodic conferences of the staff of the out-patient department to the end that the patients accepted for care shall receive proper attention.

Recommendations

"The committee recommends that:

A. The American Hospital Association adopt a statement of minimum requirements of an acceptable out-patient department which shall include the thought of the above five points.

B. The trustees, through the executive secretary and in such other ways as they may deem proper, secure the endorsement by other organizations of the final statement of minimum requirements of an acceptable out-patient department."

The committee on out-patient work in connection with this report presented a statement issued by the Associated Out-Patient Clinics of New York, including five fundamental standards, agreeing in principle with those named above. This statement of the standards, which in part is printed below, was endorsed by over one hundred representative physicians in New York City and by the public health committees of the King's County Medical Society and the New York Academy of Medicine, and was printed for the profession of the country in a bulletin of the American Medical Association.

The clinic examining and treating patients while they are up and about is of great medical importance. In the clinic it is possible to make an early diagnosis and provide effective treatment for many serious diseases, while they are still in a curable stage. The clinic can alleviate suffering and inefficiency due to chronic conditions and prolong the productive life of the patient. Many distressing diseases or defects of special organs or functions require the facilities and services of a specialist which large numbers are unable to obtain except through the out-patient clinic.

The association of out-patient service with hospital beds is mutually advantageous. The patient may thus be cared for at all stages of an illness, the beds providing for the most acute period or for surgical operation, the out-patient department for the early stages and for the after-care necessary to restore health completely and to ascertain end results.

The out-patient department of the hospital generally treats at least five times as many persons as are cared for in the wards during the same period. For example, some five million visits are made by patients to all the clinics in this city annually.

The clinic is an important agent in the prevention of diseases and in the organized public health movements of today. It provides a connecting link between the hospital and the community. In the clinic there is special opportunity for the close association of social service with medical service. In certain branches, such as pediatric and cardiac clinics, this association has been shown to be an essential part of the clinic's effectiveness.

In the education of the medical student and as a field for research into the causes and methods of treating disease, the clinic is of increasing importance.

In opening the discussion of the report Mr. Michael M. Davis remarked that care should be taken in any standards that might be officially adopted to avoid giving the impression either that every hospital must have an out-patient department or that every out-patient clinic must be attached to a hospital. The committee on out-patient work had the evident intention of including in its standards only out-patient departments of hospitals which, of course, constitute the largest and most significant out-patient clinics in the country.

"As I listened to this report," said Mr. Davis, "I had in mind an out-patient department of a small hospital in a town of Indiana receiving about fifty patients a day, and a companion picture of a clinic of a great hospital in New York City, where the number of patients in a day often reaches one thousand. Can there be standards which will have practical application to a very little place and also to a very big one, and also to the average sized out-patient department? This was the question running through my mind during the reading of the report.

Are Standards Universally Practical?

"Yet, as I listened, I remembered that there are certain principles of mechanics which will apply to every automobile, whether it be a $400 Ford or a $10,000 Rolls Royce, and I came to the conclusion that the committee had answered the question itself, and answered it well, by presenting as standards, principles and not detailed directions.

"With the five points in the standards recommended by the committee, I think there can be little, if any, disagreement. Close affiliation with the hospital; adequate records and laboratory service; carefully selected and well organized medical staff; sufficient, trained non-medical assistance; staff conferences for review of work. No one will doubt that these are all points of fundamental importance to the proper practice of medicine for ambulatory patients. It would have been possible to add considerably to the list of desirable points or principles, but I think the committee has shown wise restraint in restricting the number.

"Now the question arises whether out-patient service has reached a point throughout the country where a national organization like the American Hospital Association can wisely adopt standards and put the weight of its authority behind them, of course, only in an advisory way.

"I have given a good deal of consideration to this question because I should greatly deplore the premature formulation of standards for out-patient service. You cannot force the situation any more than you could make a child grow up straight and tall by drawing him out on a stretching machine. My conclusion is, however, that the time is ripe for the adoption by the American Hospital Association of some standards such as these, and that the existence of such standards with the sanction of a national body will be of substantial aid to the hospitals now maintaining out-patient departments in improving their service to patients, as well as in increasing the number of institutions which are annually establishing out-patient clinics or enlarging and reorganizing those already established.

"Five years ago I should have questioned whether the adoption of such standards would not provide a false stimulation. There has been, however, such rapid development in out-patient service of late years, both qualitatively and quantitatively, that I have come to the conviction that the adoption of these standards by the association will serve to consolidate progress that has been

made and to advance out-patient work in the future, and not to stimulate it falsely or prematurely."

Dr. John Osborne Polak, professor of obstetrics, Long Island Medical College, Brooklyn, N. Y., a clinician distinguished for his practical work as well as for his teaching in behalf of the advancement of better maternity service in the community, gave a characteristically forceful and interesting paper on "The Relation of the Out-Patient Department to Community Health from the Viewpoint of the Medical Profession." He said in part:

"The public has begun to recognize that it is good economy to keep people well. We are spending millions in the regulation of our water supply, to inspect our milk sources, protect our oyster beds from sewage, and carry forward periodic examination of school children, with the result that typhoid, typhus and other intestinal diseases are almost unknown, and contagious diseases among children are largely localized and controlled.

"To augment this good work the dispensary must become the teaching center of the community in all things medical. In this work it has a five-fold function:

"(1) To prevent the spread of disease; (2) to treat the ambulatory sick and surgical emergencies; (3) to teach the value of diet, exercise and hygiene; (4) to train the physician and nurse in diagnosis, technique and treatment; (5) to instruct the student and graduate in the art of medicine and practice of surgery.

"Properly to fulfill these aims dispensaries must not suffer, as many are at present suffering, from the lack of proper physical plant, inadequate laboratory facilities, and lack of organization or proper supervision of the medical staff. And my observation is that the last named is the most serious and prevalent. This may sound heretical but I venture the statement that the graduate of today, although he is better read and has had a better laboratory training, is not so well equipped for general practice as was the graduate of twenty years ago. He misses the guidance of the preceptor, the contact of the individual, and therefore fails to utilize his sixth sense—common sense. Proper supervision is the outstanding need in dispensaries today. It can be obtained only through establishing a minimum standard, living up to it, and then educating our boards of directors and superintendents.

Dollar Goes Further in Dispensary

"'A dollar invested in the dispensary goes many times further than a dollar invested in the hospital" says Dr. Paine. I will go further and say that an hour spent in the dispensary gives a return to the physician that is far out of proportion to an hour spent in the hospital.

"Another thought which certainly merits consideration is the economic waste seen in larger cities through the duplication and multiplication of special clinics. Why should special clinics, such as eye, dermatology, oral surgery, psychiatry, and others be included as a part of every dispensary and occupy space and use the funds that rightfully belong to medicine, surgery, obstetrics and pediatrics? Surely there is no one who will contend that the special hospitals are not better equipped and better manned to give treatment in these specialities."

Dr. Polak closed his talk with the statement: "Conscientious and productive work in the dispensary should have its compensation for the doctor either on the basis of a pay clinic, or by the recognition and promotion. This presupposes the adoption of the merit system and would make dispensary places sought after."

"Our business men must be convinced that good diagnosis and treatment in the out-patient department will save hospitals thousands of dollars in unnecessary work, and employers even larger sums in lost time of employees.

The community relations of the out-patient department viewed by Dr. Polak and by hospital administrators from the inside looking out, were approached by Mr. Sherman Conrad, director, New Orleans Community Chest, New Orleans, La., from the outside looking in—a fresh and stimulating viewpoint. Mr. Conrad gave hospital people an opportunity, which is unfortunately too infrequently provided, to see themselves as outside agencies in the community may see them. Under the title "The Relation of the Out-Patient Department to Community Health from the Viewpoint of the Welfare Agencies" Mr. Conrad spoke of the need which charity organizations, children's welfare organizations and other non-medical, social agencies feel for having careful medical examinations for their beneficiaries and medical advice and treatment when these are required. Sickness, both its cause and its effect, is

Three prominent out-patient workers. (Left) Alec N. Thomson, chairman, out-patient committee; Sherman Conrad, director, Community Chest, New Orleans, and Dr. John Spelman, superintendent, Touro Infirmary, New Orleans.

so closely connected with poverty and with other evils with which philanthropic agencies are wrestling that the hospital and more particularly the out-patient department needs to serve as the medical examiner and adviser for these dependent members of the community who cannot provide for themselves and who are under the guidance of some organized social agency.

Too often, said Mr. Conrad, the social agency which sends its clients to the dispensary finds inefficient service and insufficient cooperation. As an example he mentioned an orthopedic clinic for which the staff of a social agency had worked hard to assemble a number of crippled children from a wide area. After a two hours' wait, while the orthopedic surgeon was busy elsewhere in the hospital, the children and the social workers were told to come back a week later.

Overcrowding of clinics, and difficulty in securing needed reports were among other obstacles that social agencies found in securing from dispensaries the cooperative service which, as Mr. Conrad rightly felt, should be rendered by dispensaries since they are founded and supported by the same community which maintains the non-medical charities. Mr. Conrad gracefully made it clear that he realized that he was presenting only one side of the story; that much valuable service was given by the dispensaries and he doubted not a list of faults of the social agencies could also be presented by the medical institutions if they were to have their innings.

MANY NEW IDEAS PRESENTED FOR APPROVAL OF THE ASSOCIATION

Reported by Asa S. Bacon, Superintendent
Presbyterian Hospital, Chicago

PROBABLY greater strides were made by the association in meeting problems that affected the association itself than in previous years. Changes in the constitution and rules, the proposed changes in the standards for membership, the new methods of appointing the nominating committee, the decision to purchase a home of its own in Chicago and other important matters were acted upon. Executive Secretary Dr. Walsh reported upon the activities during the past year and told of the ambitions of the association. The trustees reported the arduous work that the board has been doing and the National Hospital Day Committee told of the progress that has been made in furthering the interest in this feature of the association.

This year the treasurer was able to report a larger surplus than in former years and with this as a nucleus and foundation the purchasing of the new site for the association headquarters was assured. The resolutions that were reported by the resolutions committee proved that the association was keenly interested in all of the problems that would affect hospitals in every part of the country, irrespective of their size or the character of the work that they were engaged in.

Asa S. Bacon, re-elected treasurer, and (right) Thomas F. Dawkins, superintendent, Union Hospital, Fall River, Mass.

Several interesting round table discussions were heard at the Monday afternoon session of the convention and such topics as the need for a field secretary, what members can do to further the interests of the A.H.A. and other points of interest were brought up and talked over. While the acoustics of the hall proved to be poor, by an arrangement of the speakers in the middle of the hall those attending the session—by far the largest of the convention—were able to hear clearly.

With the ambitious program that has been outlined by the association for the coming year, and the committees that have been appointed, it is anticipated that the sessions next year will show still further interest in the work that the A.H.A. is doing and its objectives.

The proposition for the new home was presented for the consideration of the association by Richard P. Borden, senior trustee, who described in detail the plans for acquiring the new headquarters. The proposed home is a three-story building at 18-20-22 East Division Street, Chicago, appraised at $140,000 but now under option at $125,000. Mr. Borden pointed out the advantageous features of the site with respect to its favorable location and the adaptation of the building as it stands to the purposes of the association. The property includes the main building and an adjoining building adequate for the present needs of the association and with additional room for housing a number of allied associations. A picture of the proposed home was shown on a screen. He stated that the association had consulted one of the most reliable banking concerns, the Union Trust Company, in regard to the details of the purchase. The plans as worked out propose a payment of $10,000 in cash, leaving a first mortgage of $60,000 and giving a mortgage of $60,000 to the Union Trust Company for bonds, which will be purchasable in denominations of $100 and $500 to hospital people providing $5,000 for alterations.

The report of the nominating committee was presented by L. G. Reynolds, superintendent, Methodist Hospital of Southern California, Los Angeles, who presented the following nominations: for president, C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.; first vice-president, T. J. McGinty, superintendent, Baptist Hospital, Louisville; second vice-president, Blanche Fuller, superintendent Nebraska Methodist Episcopal Hospital, Omaha; third vice-president, W. W. Kenney, superintendent, Victoria General Hospital, Halifax, N. S.; for treasurer, Asa S. Bacon, and for trustees, the Rev. Maurice F. Griffin, Youngstown, Ohio, and E. S. Gilmore.

Supplementing the report of the committee the names of R. G. Brodrick, superintendent, Alameda County Hospital, San Leandro, Calif., for president, and Dr. Walter H. Conley, director of hospitals, Department of Welfare, New York, were nominated from the floor.

The report of the board of trustees, presented by Richard P. Borden, chairman, summarized the outstanding accomplishments of the year and the plans of the board for the near future. One of the foremost features of the report was the proposal of the project for the new home for the association discussed above.

A significant step was taken with respect to the study for grading nursing schools. In response to the invitation of the National League of Nursing Education the association appointed Dr. Goldwater, with the secretary, as alternate, to represent the association in the study looking toward the grading of nursing schools.

The committee proposed that the activity of National Hospital Day be conducted from the central office to avoid duplication and confusion and that a general chairman be appointed with sub-committees in different sections.

An amendment was suggested to the constitution changing the name of the association to the "North American Hospital Association."

An invitation is under consideration from the National Health Council to affiliate with that body on an active basis coordinate with that of the American Medical Association and other medical and health associations.

In response to the requests to help in improving the conditions of prison hospitals the board authorized the secretary to cooperate with the National Society of Penal Information to the extent of suggesting capable hospital

men who may accompany the society's inspectors on their visits to prisons, to the end of better functioning of these hospitals.

Among the other accomplishments of the year was the appointment of the new executive secretary to succeed the late Dr. A. R. Warner, the organization of a personnel bureau and the publication of six special bulletins, three of which were on technical subjects of vital interest to members of the association.

The membership committee reported a steady gain in membership, not only from a numerical standpoint but also from the standpoint of the quality of institution accepted. The committee also suggested that applicants be required to reach a certain standard before being considered.

By a resolution offered the standard would be within the reach of small and large hospitals alike. Actual attainment of the requirements would not necessarily debar the applicant so long as the membership committee could feel assured that these ideals were being striven for and that the applicant subscribed to them.

The outlined plan would indicate a board of trustees, no member of which would be on the active or consulting staff of the hospital. Hospitals under religious control with no board of trustees should appoint an advisory committee. The indorsement of the approved accounting system of the A.H.A. is another requisite. An organized medical staff with monthly meeting, laboratory facilities, an adequate record system, a nurses training school, internship, the dietitian classed with the scientific personnel and qualified social service workers are required as well as the abolishment of fee splitting.

C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., who was chairman of the National Hospital Day committee and (right) Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, chairman of the legislative committee.

The report shows that at the time of this convention there are 882 institutional members and 1,808 personal associates of the American Hospital Association. By the end of the year it is expected that there will be over a thousand hospitals in the association.

Dr. E. T. Olsen superintendent, Englewood Hospital, Chicago, chairman of the legislative committee presented his report. The report this year was more comprehensive than it has previously been and among other suggestions, the founding of a legislative bureau by the association was recommended. This recommendation was based upon a questionnaire on the subject that was answered by the secretaries of fifteen state associations.

In furtherance of other subjects that appeared on the same questionnaire the committee urged that the state associations be advised to carefully scrutinize all proposed legislation that directly affects the care of the sick in hospitals and to oppose actively the passage of unnecessary or adverse legislation.

In discussing the report of the legislative committee Dr. W. P. Morrill, superintendent, Columbia Hospital, Washington, D. C., said that the task of scrutinizing legislation had become so great that it could not well be handled longer by the committee and volunteers, but that this group should form the nucleus of a legislative bureau similar to that proposed by in the report of the executive secretary.

In his paper on "The Value of a Field Secretary to the American Hospital Association," I. W. J. McClain superintendent of St. Luke's Home and Hospital, Utica, N. Y., outlined the qualifications and duties of such an officer. He said in part:

"It is self-evident that the man for so responsible a station should possess ample literary training and a strong but magnetic personality. In addition to this long experience in all phases of hospital construction, organization, equipment and management is a predominant prerequisite. It is essential that he possess ability to interpret human nature, to impart wise counsel, to recognize a proper balance and proportion in standards for the future association and hospital programs.

"Through a field secretary contact would be established between the individual hospital and the American Hospital Association, as cannot be done in any other way. A field secretary would make the American Hospital Association a real, live entity to all hospitals upon which calls would be made. A field secretary would establish the missing link which would bind together the individual hospital, the state association and the American Hospital Association, and make more direct the benefits from the American Hospital Association to the hospitals of various states and districts through attendance at their respective metings and conferences, especially when geographical variations may be a factor.

"Among the duties naturally falling into the program of a field secretary might properly be included the relief of the executive secretary in the home office when business and important conventions call him from Chicago; investigation of qualifications of applicants.

The report of the executive secretary was given by Dr. William H. Walsh. Dr. Walsh briefly described the preparation and arrangements of the association for the convention and proceeded with a summary of the various angles of service now in progress and those that are being planned for the near future. In regard to membership he showed that institutional members had increased to almost 1,000 with a goal set for 4,000 and that personal membership had reached the 2,000 mark with a goal set for 6,000.

With respect to the treasury Dr. Walsh said: "Our treasury is in better condition than ever before in the history of the association, as all our current bills are paid and we have a comfortable balance in the bank. On the other hand, the demands for more service are more urgent and as will be hereafter indicated, contemplated extensions will require the most careful financing."

He said that commencing with January 1, 1926, the association hoped to adopt a budget system that would enable it to apportion its resources more accurately.

He briefly outlined the work of the new personnel bureau which has been in operation since July 1, and summarized the advantages of the bureau.

The report also outlined the work that has been done in cooperating with other allied associations to be of mutual assistance in matters where hospital interests are a consideration.

The report of the resolutions committee was read at the closing session of the conference by Dr. Louis H. Burlingham, chairman, who presented the decision of the committee upon the various resolutions and reports submitted to it during the conference.

With respect to the motion that the president be requested to appoint a committee to consider the advisability of forming a committee for the study of the subject of county hospitals, it recommended that the president be instructed to appoint such a committee.

Approval was given of the recommendation of the A.H.A. dietetic section in the report of the committee on foods and equipment for food service that a committee be appointed for further study and report to the association.

The report of the membership committee was recommended for approval and acceptance, as the committee felt that the standards set were sound but that in the actual application, as indicated in the body of the report, care and discretion should be used.

The report of the intern committee was heartily approved, particularly with respect to the recommendation that the association be adequately represented on the Council on Medical Education and Hospitals of the American Medical Association, and recommended that the association take early action upon this matter.

The report of the legislative committee was recommended for approval and emphasis placed upon the necessity for creating a legislative reference bureau as soon as possible, and that the present committee continue to function until such a bureau is established.

Congratulations were extended to the members of the committee on the training of hospital executives upon the thorough manner in which the problem was treated in the report. It was recommended that the report be approved and referred to the board of trustees for appropriate action in carrying out the recommendations of the report.

The report of the out-patient committee was also recommended for approval and adoption.

A motion was also made at the meeting that Dr. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md., who was unable to attend the meeting on account of serious illness, be made an honorary member.

DIETITIANS HOLD INTERESTING SESSION

THE dietetic section of the American Hospital Association held its meeting in the main hall of the armory on Tuesday afternoon, the chairman of the section, Miss Lulu Graves, presiding.

Mr. Paul H. Fesler, superintendent, State University Hospital, Oklahoma City, Okla., the chairman of the committee on foods and food equipment, read the report of that committee.

The report of the committee on food and equipment for food service dealt with the problem from the administrative standpoint in order to bring about a more complete understanding between hospital administrators and those responsible for dietary departments.

The chief interest of the committee was in connection with such of the seven thousand hospitals of the country that are without the service of a trained dietition. In most of these hospitals the responsibility for food service depends upon a nurse who, in many instances, does not have the knowledge or training to fit her for this position.

One of the important phases of the report dealt with the problem of education. In addition to her ability to plan menus, purchase, have charge of her help, the dietition must be able to educate the student nurses, the report stated. In most schools the nurse receives only a few hours instruction in dietetics, and that only in the preparation of special diets and in the preparation of an attractive trya for the private patient.

Miss E. Moreland Geraghty, Lakeside Hospital, Cleveland, opened the discussion. She agreed with Mr. Fesler that the greatest problem is that of education, since we need to educate each group in the hospital. The education of the nurse is of great importance, but in the limited amount of time allowed for theoretical and practical instruction, it is impossible to give the nurses sufficient instruction, and training to enable them to take charge of the department of dietetics in smaller hospitals. In order to do this a postgraduate course would be needed.

Mary Foley, Mayo Clinic, Rochester, Minn., made a motion that the secretary of the section send a recommendation to the resolutions committee of the American Hospital Association that a committee be appointed to study the problems suggested in Mr. Fesler's report and that such a committee be made up from the hospital, dietetic and medical group. This motion was carried.

Mrs. Mildred Chase Cooke, superintendent, Chase Sanitarium, Los Angeles, Calif., said that a dietitian can more than save her salary, even in the small hospital, by proper management and coordination.

Mr. Henry G. Yearick, director, Homeopathic Hospital, Pittsburgh, Pa., said that it is folly to say that a dietitian is an expensive luxury for the small hospital because she has a real function, will give value received and hospitals cannot afford to be without a trained dietitian.

Miss Graves, in concluding the meeting, called attention to the fact that the business world is recognizing the value of the dietitian and the hospital will be forced to recognize that value as well.

Dr. Ruth Wheeler, University of Iowa, Iowa City, read a paper on the chief types of dietary departments, in which she stressed the growing cooperation between all departments of the hospital and gave as the ultimate purpose of the dietary department the proper preparation and service of foods and the organization of the department in such a way that it may function more efficiently.

The committee's plan of organization, with a specialist heading each department is the type of organization advocated by Dr. Wheeler for the larger hospital. This form of organization affords opportunity for close cooperation between superintendent, doctors, dietitians and nurses, and makes possible the carrying out of the purposes of the department.

No discussion followed Dr. Wheeler's paper.

Mr. George W. Alder, consulting engineer, *Good Housekeeping*, presented a paper on "Selection and Testing of Equipment," and said that the first thing necessary is to know what you want and what you are looking for. Knowledge is essential in order to get the equipment that is adequate and satisfactory for your particular need. There are many reliable sources from which this information can be obtained in an absolutely unbiased way, such as the American Gas Company, who will give information on stoves and kitchen equipment in general.

Mr. Alder also suggested that it would be valuable to centralize information regarding different types of equipment used in hospitals all over the country and keep this on file along with catalogues of manufacturers. Then hospitals selecting new equipment would have a source of information.

ADVANCEMENT IN CONSTRUCTION IS SHOWN BY REPORTS ON BUILDING ACTIVITIES

Reported by Frank E. Chapman, Superintendent,
Mount Sinai Hospital, Cleveland

THERE is no gainsaying the fact that the section meetings of the American Hospital Association have been the means of developing a little bit different type of program than it has been possible to present in the general meetings. It is in these sections that intimate discussion of specific problems has been possible, rather than the general discussion that has been prevalent and in fact necessary in the general meetings.

The section on building and construction has always been one of the outstanding sectional meeting developments, and under the leadership of its officers has each year rendered a type of service to the hospital field that is indeed commendable. The result of its various meetings leads one to hope that these developments in the association will be continuous.

The report of the committee on buildings, presented by Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, chairman of the section, and printed as a part of the proceedings of the meeting, is a very graphic illustration of the type of service these sectional groups have developed. The report in its entirety is an exceedingly inclusive reference list, suggesting and apparently solving every problem that is met with by a building committee, architect or consultant in the development of plants for private patients.

In presenting his report to the section Dr. Goldwater impressed upon all that there was no thought in the minds of the committee that the report be considered in its entirety, that in such an extent a development so ensuing would be extravagant to a degree, but that the purpose of the report and the thought of the committee was that this report would furnish a means by which problems could be suggested to committees, these problems to be considered, and accepted or discarded in accordance with the desires of the particular development.

Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland.

Unfortunately there was no additional report of the committee on building codes this year. This is a very definite problem and one that warrants continuous study.

Making a hospital of larger bed capacity and of class A standards out of a small institution, is a serious matter under the best of conditions. If a small hospital has already established high standards the task is of course much simpler and the matter becomes a problem of gradual growth and there follows a sane adaptation of small departments and activities to develop them to the larger capacity. If, however, the small hospital has had uncertain standards or none at all, the task becomes a Herculean one, and the work and worry and heartache involved can be known and appreciated only by those who have had to live through it and endure it.

In the first case where development comes from the small class A institution to the larger class A institution, if such growth is engineered sanely, it rests upon the caliber and intent of the board of directors of the hospital to support the existing administration, and each department and each committee of the board itself, with sufficient money and encouragement to study and carry out its own salvation. In cases where substantial organizations and efficient personnel do not exist, or the board or its committee feel unequal to such a task, time and money will be saved and future trouble avoided by the employment of authoritative people to give counsel and advice. In this case much of the unnecessary antagonism and personal resistance may be avoided.

Drastic methods of organization which deny the right of opportunity to the people already on the ground without reference to their ability to re-educate themselves and carry on, and any domineering attempts to make a clean sweep of everybody concerned, are not necessary and produce more antagonism than the average board or administration "can get away with" and make good on the job.

Few tasks require more careful study and team work and human touch than this one of making the little hospital into a big one. This holds true along the whole road to be followed.

There are very few of us who are not sooner or later confronted with the problem of expansion and in his paper entitled "When the Smaller Hospital Decides to Become a Larger Hospital. What Then?" Dr. Martin J. Westervelt, superintendent, Staten Island Hospital, Tompkinsville, N. Y., suggested a means of developing such expansion that was well presented and full of essential truths. Dr. Westervelt stressed the point that the hit and miss method of development was bound to be productive of unsatisfactory results, and that the first step in any expansion program was an analysis of the existing facilities of the hospital and an evolution of the approximate demands of service. This should be followed by an intimate study to ascertain if it were possible that these demands could be met by rearrangement of present facilities.

The doctor in presenting this point called attention to the fact that in a great many instances demands for additional service were demands made necessary as a result of inflexible original planning and lack of ability to rearrange existing facilities to meet changed demands. The doctor made the further point that one must not overlook the fact that in any program of expansion, any plan for additional beds, there is an absolute necessity to furnish increased and additional service facilities.

It has proved in the particular instance in which Dr. Westervelt has been involved that the average method of boards of trustees and directors who start out to make additions is not founded on the correct basis. For instance, the usual thought is that if a hospital needs more room for private patients the thing to do is to erect a pavilion or addition for these patients. Dr. Westervelt says that when this method was followed at his hospital the first plans had to be completely set aside, and new plans made on the basis of the findings of a survey of the needs of the existing plant for expansion, which included, first, a study of the shortcomings of the existing plant; second, the possibilities of avoiding cramped conditions by readjustment and, third, a plan to meet the future growth. When this study was completed it was found that many services could be readjusted by rearrangement of existing capacity.

Charles S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia. (Left) and Charles F. Neergaard, hospital consultant, New York.

While physical reconstruction was going on a study was made of the corresponding increase of costs of maintenance, increase of personnel to meet the future plan and serious attention was given to the future needs of the community. It was found while this reconstruction was going on that practically every department of the hospital had to be stretched to meet the proposed capacity. The gist of this paper and the value of this constructive thought was this: No particular expansion of a hospital involving increase of bed capacity should be made without a comprehensive plan being made to cover the added growth in the departments involved. This applies to administrative and mechanical facilities, as well as to nursing quarters and dietary and house hold departments.

In addition to his very important constructive criticism of present methods, Dr. Westervelt stressed the fact that when all plans were made after a definite survey of conditions, in such a way that a definite picture could be presented of the needs for growth, it was possible in making an appeal for funds to show to the prospective giver departments and rooms which proved to be attractive for gifts and memorials. This does away with the constant question: "When and how is the money that we have given being used?"

Another point that was very well made was a discussion of the relative value of developing a plan for the immediate expansion program, or, on the other hand, developing a comprehensive scheme of planning over a period of years. It was the consensus of opinion of those discussing the doctor's presentation that a comprehensive plan or program for expansion and development over a period of years was the proper method of approach.

Dr. Westervelt's paper called forth quite an interesting discussion.

Perhaps the most spectacular item in the construction section meeting was an analysis of hospital plans by the use of colored crayons by Myron Hunt, architect, Los Angeles. Many of us who handle hospital plans continuously were impressed by the vividness of Mr. Hunt's presentation, and all who heard the article must have been brought to the realization that intimate, intelligent analysis of potential plans of development must produce a more satisfactorily finished hospital.

EXPOSITION OF EQUIPMENT OFFERS WEALTH OF INFORMATION

ONE of the earliest contacts that I had on arriving at the exposition hall was with the president of the board of trustees and the chief of staff of a hospital that is now in process of development. These men, in commenting on the commercial exposition, made the statement that they were able as the result of one night's travel and a relatively small expenditure of money to gain a knowledge of the hospital equipment field such as it would not have been possible to gain in any other way, even with the expenditure of many times the amount of energy and funds.

This comment crystallizes the impression that has been growing in my mind. I am wondering to what degree those of us for whom these expositions were created realize the potentiality for informative contacts that there is in these expositions. I am wondering if we in any sense of the word secure to ourselves the benefits that are ours for the asking. I am wondering to what degree we are availing ourselves of this vast wealth of information. I am wondering if we are looking at the exposition in terms of the educational value thereof, rather than in terms of the commercial aspect of the vast group of diversified commodities that are displayed.

It would be impossible for any one individual intelligently to cover and discuss all of this exposition, and my purpose is to give an impressionistic survey of those phases of the exhibits that have to do with construction.

Let it be understood that not many of these things are new in the real sense of the word. The comments made in this article pertain to the endeavors of certain vendors of hospital commodities to meet your requirements and they are designed to draw your attention to the fact that the salesman who calls upon you has behind him a corps of workers who are daily striving to produce for you a better degree of service by means of the practically unlimited facilities at their command for developing new things and new ideas for the improvement of your service.

I should like to enter a plea here for a different point of view toward the commercial exhibitor and ask you to realize that his success is predicated upon his ability to develop your ideas and ideals into a tangible contribution to hospital service.

One of the outstanding illustrations of this idea is the contribution of one exhibitor who has produced for you and for me a most comprehensive and elaborate arrangement of signal systems. There was exhibited a nurses' call system which incorporates the usual features of expediency of calling the service and outlets at the bedside, and, in addition, radio wire terminals with head sets, which while presented the first time at last year's exposition has been developed to a greater degree of perfection this year.

A doctors' paging system was demonstrated that is unquestionably a step forward in the paging of doctors by the light system, permitting of the intermittent flashing of the code number of the individual call.

Bird's-eye view of the exposition hall showing the educational and scientific exhibits that were located on the balcony.

Facilities for the registering in and out of members of the attending staff, a fire alarm system that meets all of the most rigid requirements of various building codes, an intercommunicating telephone system and a system of time recording, round out the cycle of signal systems that are presented by this exhibitor.

We all know that artificial lighting in our operating rooms and for those services requiring a degree of illumination in an unusual way, has not been satisfactory in the past. As an evidence of this and of the vast facilities at your command are two exhibits this year, each of which is attempting to solve for you the problem of this illumination. A system of illumination that permits of a diffused lighting, eliminating the distortion incident to ordinary lighting presents a very interesting solution that would seem to leave very little to be desired.

This same idea of lighting applied to the autopsy room, with a recognition of the need for removing the central light to permit of the projection of lantern slides, etc., is also very interesting.

There is presented, further, a portable lamp that offers all of the facilities of the stationary lamp, with the added advantage of flexibility to permit of its use at the bedside or in isolated rooms.

Glass lined laundry chutes have been presented to us for several years, but this year attention is called to a

A view of the exposition hall showing some of the exhibits of technical equipment and supplies.

further development and further refinement of this service in the form of glass lined metal containers of varied sizes, shapes and character.

With the recognition that our present day methods of construction produce incidents of noise that are very trying, a well-known manufacturer has developed a method of acoustical treatment that was graphically illustrated at the exposition.

In the plumbing field very little that is new was presented this year. However, attention is called to a new type of drinking water fountain that seems to be an advance on anything previously shown.

Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, chairman of the committee on buildings—construction, equipment and maintenance.

In recognition of the eternal problem of the bedpan nuisance, individual toilets, permitting the flushing of these utensils, and a recessed bedpan washer were exhibited and are called to your attention as a new development.

Who has not had trouble with laboratory plumbing, because of the fact that in the beginning the usual type of material was used in the installation of the wastes. An acid and alkali resisting waste pipe was exhibited, illustrating in a practical way the desirability of this type of installation.

In the sterilizer field a new and practically foolproof sterilizer door, offering a greater assurance of safety, was a real contribution of the exposition.

The rubber floor manufacturers were again very much in evidence, forcefully calling the attention of the delegates to the desirability of this type of flooring. The educational value of these exhibits and the vivid illustration of what can be done with rubber was perhaps so far as construction is concerned, the outstanding contribution of the exhibitors in an educational way These exhibits in addition to calling attention to the use of rubber for flooring purposes, illustrated food cart and truck bumpers, chair rails, bumpers for beds and a new method of protection against the Roentgen ray by a combination of litharge and rubber.

Refrigerators came in for their share of consideration and those displayed illustrated the refinement of the self-contained refrigerating unit for isolation and small service demands.

There was also an advanced idea in the use of glass for partitions and wall covering, in the form af a laminated glass panel that has a structural strength and imperviousness to absorption and an esthetic appeal that are very well worth while.

In the early centuries all hospitals were of the same general kind, but later they were separated into general and special hospitals. Among the latter were the manicomia, the syphilicomia, or hospitals for venereal diseases, special hospitals for skin diseases, and for diseases of children.

DEFINITE STANDARD FOR OCCUPATIONAL THERAPY WORK NEEDED

In his speech, "The Present Status of Occupational Therapy in the Hospital Curriculum," Dr. John Adams of Boston, Mass., stated that the medical profession had become more and more critical in accepting any innovation or new treatment unless its position could be substantiated by facts and good results to the patient. Occupational therapy has met with the usual amount of criticism and condemnation and has passed through the developmental stage that might be likened to the children's diseases, but it is now prepared to present facts and figures that, in the opinion of those qualified to express themselves, substantiate its right to occupy its position in the hospital curriculum.

A definite standard of work is necessary if occupational therapy is to maintain its position in hospital work, Dr. Adams stated. It is essentially therapeutic in its basic principles and therefore its very existence is contingent upon its acceptance and belief by the medical profession and the hospital personnel.

Dr. Adams outlined the war work and told of how the schools and occupational therapy departments are functioning.

He urged those connected with this interesting work to strive for the highest standards possible so that occupational therapy would do its utmost for humanity. He stated that the ideal treatment combined physiotherapy and occupational therapy and cited instances where excellent results had been accomplished by this combination.

"Even the most enthusiastic supporters do not consider that occupational therapy is a cure-all," he stated. "It is simply an adjunct in the medical treatment of patients and applicable to only that type of case where restoration of functions, either mental or physical, is to be considered." He then outlined the work that has been done in various types of special hospitals and the different grades of work. He ended his paper by paying tribute to the work done by the prevocational and the vocational work among the permantently handicapped.

In discussing Dr. Adams' paper T. B. Kidner, president, American Occupational Therapy Association, New York, gave a brief resumé of the development of this work in the hospitals of the country during the past ten years and the place that this field is receiving in educational institutions. At present there are 150 therapists in training in schools, he said, and there are 764 hospitals that now have permanently established occupational therapy departments. He said that a step of significance was about to be taken by the American Occupational Therapy Association in establishing a national register of qualified persons for occupational therapy instructors to facilitate the contact of hospitals with trained workers.

DISTINGUISHED ITALIAN ORTHOPEDIST VISITS AMERICA

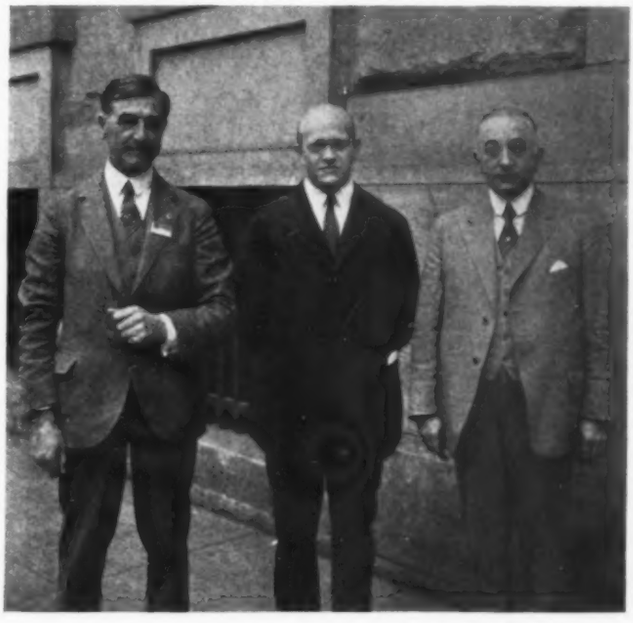
One of our distinguished visitors this month is Professor Vittorio Putti, professor of orthopedic surgery in the University of Bologna, Italy, and director of L'Istituto Ortopedico Rizzoli. Professor Putti accepted an invitation to attend the clinical congress of the American College of Surgeons that was held in Philadelphia the week of October 26. At the Tuesday session he delivered a paper on "Congenital Dislocation of the Hip." Other hospital men and physicians will have an opportunity of meeting him, as it is understood that he will travel across the continent to attend other meetings. (See page 368.)

OBJECTIVES OF SERVICE DESCRIBED BY HOSPITAL SOCIAL WORKERS

THE semi-annual meeting of the American Association of Hospital Social Workers was held in Louisville, Ky., in conjunction with the annual meeting of the American Hospital Association. The program provided interesting discussions on the relationships between the hospital and the community and the part played by social workers in strengthening that relationship.

Edward A. Fitzpatrick, educational director, College of Hospital Administration, Marquette University, Milwaukee, Wis., emphasized in a convincing fashion the responsibility and the opportunity of the hospital social worker in the hospital's now recognized place as "one of the community agencies for social welfare, especially directed to preventing physical breakdown or disease, and to caring for and curing the sick."

He contrasted the present day hospital with that of the past. The old hospital was considered an institution solely for the indigent sick; the new hospital exists and is organized for all classes, rich and poor alike, and in its essential services all classes receive the same treatment. The old hospital "was conceived as a place people went to as a last resort when the issues of life and death were at stake; the new hospital is a place where people go willingly to learn how to improve their physical condition, to anticipate possible trouble, to take preventive measures against contagious disease.



Dr. R. G. Brodrick, Dr. A. C. Bachmeyer, and Dr. Walter H. Conley.

"In the older hospital the diagnosis of the individual's sickness was based upon certain symptoms described by the patient himself, and on such observations as the doctor could make in his visits. In the new view every scientific resource, every insight and every iota of information of the economic, social and personal life of the individual is brought to bear, and systematic observations of trained nurses and interns are regularly recorded, making diagnosis less and less a matter of approximation or guess.

"In this social transformation of the hospital the social worker is an important factor, and perhaps not less so in the medical transformation of the hospital. The new resources of diagnosis which the hospital laboratories furnish to the medical practitioner tend to emphasize the treatment of the sickness rather than the treatment of the sick person. This has a tendency to make the practice of medicine more impersonal, and while bringing to bear entirely new and helpful factors in diagnosis, unless supplemented by the viewpoint of the social service worker, it tends more and more to a standardized routine treatment of disease, instead of an intimate, personal consideration of all the factors, including the laboratory facts, affecting the physical well-being of the person.

"The important thing in the diagnosis of a disease is not the fact of disability, but the causes that led to the condition. This will require practically a review of the entire life of the individual, with special reference to the causes contributing to the present condition. These are not primarily medical facts, but social facts, the individual's reaction to his environment. They are facts regarding the person's diet, the conditions under which he lives in his home, the conditions under which he works in the shop, the nature of his recreation, any facts of heredity or family history indicating tendencies to disease and his resistance.

"Nor is the social worker less important in the treatment aspect of disease. Too largely we have conceived of medical practice as dealing with operations and whatever help could subsequently be given from the pharmacopeia. Even in the immediate treatment of disease drugs are not a major factor; diet, rest, avoidance of strain, and a careful regime of living contribute to the cure. In such a program, again, the nature of the patient's home environment, the compatability of the person with whom he comes in contact, the nature of his work, the nature of his recreation are factors that can more adequately be taken care of by the social worker than by the physician himself. And if the treatment requires a period of reconstruction in addition to the curing of the disease, then, these same factors that the social worker contributes are of extreme importance.

"If these are the factors in the diagnosis and treatment of people who are sick, and the complete restoration of full activity in the community life is so dependent on the social worker, then it ought to be obvious that from the standpoint of the community relation of the hospital, the social worker is the most important person, because it is upon her that the clinician and surgeon must rely for the information necessary for (1) an accurate diagnosis; (2) an intelligent and progressive treatment of disease, and (3) an ordering of the person's life so that proposals for cure and reëntry into community life are effectively carried out.

"The social worker becomes the liaison between the physicians and the entire community resources for individual reconstruction. The plan of treatment is the plan of the doctor, and the social worker's information and interpretation of facts must be utilized in connection with that program. There is no desire to set up the social worker as an entirely independent agent. She is part of the entire hospital program.

Booth of the American Association of Hospital Social Workers where were displayed posters and charts representative of what is being accomplished in that field.

In securing the data upon which the doctor can make his diagnosis, the social worker comes in contact with those general conditions, social and economic, that cause individual maladjustment or breakdown of physical capacity. In this way the social worker discovers the conditions with which the public health program of the community is vitally concerned in its immediate remedial work, and ultimately in its preventive work. By revealing to the public health agencies and to the general social agencies of the community the direct relation between social conditions and physical and mental breakdown or disability, the social worker becomes one of the most influential clearing houses in the community, and strengthens the community relations of the hospital. If the social worker is not buried in the clerical work of administration or in routine statistics, but has the opportunity for first-hand investigation, and for interpreting the organized data she develops, then the hospital becomes not merely an agency of calling attention to problems, but a vital factor in working them out.

So the social worker is in fact the liaison of the hospital so far as its community relations go. She brings to bear upon the problems of the sick the entire social resources of the community for the complete recovery of the patient, and his taking up again actively his place in the community life. In all of these contacts she educates the social agencies to the new, social, constructive and regenerative effect of the hospital. At the same time she calls the attention of the doctors continuously to the social origin of disease and to the agencies in the community available to assist them in their great work. To her great honor is due for the social and human rconstruction of the hospital.

Mr. Fitzpatrick's paper was discussed by Dr. Stuart Graves, dean, medical school, University of Louisville, who corroborated the statements made and considered some of the difficulties of the public hospital administrators who must "sell" the newer conception of the hospital to the public authorities and the public at large. Dr. Graves concluded his discussion with the statement that "the social worker is indispensable to the doctor today. Only by cooperating can both in the modern clinic treat the patient successfully in body, mind and spirit. The sooner the social service department can be developed to its fullest possibilities, the sooner can the hospital render its full measure of service. It is our duty to drive home this conception to those who support the hospital."

Miss Kathleen Allen, University of Michigan Hospital, Ann Arbor, Mich., gave a striking picture of the work done by the state hospitals through their social service departments. She spoke of the social worker as the coupling pin, tying the hospitals with the community. Through work with the patient, she speaks to his family, his lodge, club, church and friends. Completeness of work for the individual will mean dividends for the community.

Dr. Leland B. Alford of St. Luke's and St. Mary's Hospital, St. Louis, presented a carefully thought out paper on "The Mental Hygiene Clinic in a General Hospital or Dispensary and its Relationship to the Community." He first pointed out the position of the general hospital as a community center from which movements which it is hoped may reach the community at large can logically emanate. The mental hygiene movement in particular can look to the general hospital as a base from which the community can be reached.

In the first place, within the hospital itself, the psychiatrist has the opportunity to convince the specialists in other lines on the hospital staff of the truth of his conviction that many supposedly medical conditions are really psychiatric or neurotic in nature. The social service worker in the general hospital who has been generally accepted as indispensable should, in Dr. Alford's opinion, have psychiatric training. She must be depended upon to uncover many of the psychiatric factors which are present in the cases referred to a general hospital, and call them to the attention of the psychiatrist. The psychiatric social worker cannot do this because she has referred to her only those cases where the psychiatric aspects have already been recognized. While taking the social history of patients admitted to the hospital the social worker has a splendid opportunity to impress upon people the bearings of psychiatric forces in a way which the physician can never do. In this way the hospital social worker becomes a mental hygiene force of incalculable value in the community. Her work is concrete and reaches a class of persons which would not in other ways be touched.

Dr. Alford also brought out the point that social workers are a new and plastic group and therefore more open to new ideas than some of the older, more established professions. This characteristic facilitates the dissemination of mental hygiene ideas through them as a medium.

Dr. Alford suggests the extension of social work in the treatment of private patients, particularly psychiatric cases. Because the treatment of psychiatric cases is so largely social he feels that the cooperation of social workers with the doctors in treatment would be highly desirable.

He then went into a discussion of what constitutes rational treatment of psychosis and pointed out that not enough emphasis is put upon prevention. Because we have so little knowledge of the etiological factors in mental disease rational preventive measures are non-existent. Mental disturbance can be separated into two component parts, the one related directly to the basic process whatever it may be, and the other accessory symptoms such as delusions, hallucinations and excitement which depend in part on factors that are preventable

and removable. Fear, grief, and physical disabilities are examples. There is hope of removing the more distressing accessory symptoms in a large proportion of cases through the services of the general hospital, social service and occupational therapy.

The principles governing treatment are extremely simple. Most important is an attitude of sympathy and hopefulness, combined with the studious avoidance of anything suggesting the connotation carried by the term insanity. The psychotic patient misses no action performed or word spoken about him, and good or bad effects become evident during the period that should constitute convalescence. Here comes in the value of the general hospital making arrangements to care for patients of this type. Residence in a general hospital places his illness on a level with medical and surgical disorders and eliminates unpleasant stigmata.

More Emphasis on Family History

Since so many mental disorders seem to depend on innate and often hereditary protoplasmic defects, preventive measures should be applied to limit the reproduction of defective stocks. It is important to disseminate a knowledge of the laws of heredity. One way in which attention can be called to hereditary factors is to put more emphasis on the taking of family histories of patients. The mere taking of such a thorough history will impress all those concerned with the importance of hereditary factors. The social worker could refer to the psychiatrist such cases as need more specific advice. Dr. Alford also emphasized the need for dealing with habit disturbances of childhood in out-patient neurological clinics. Since the child is the forebear of the adult he is entitled to all the training possible which will enable him to meet the problems of life with a minimum of difficulty and a maximum of happiness. Two such clinics have been established under Dr. Alford's direction, one under private auspices and the other in connection with the neurological clinic of St. Luke's Hospital. Two interesting extensions of this work have been to include cases referred by the schools and to interest parents in homes of the better class. Children from any class of society are treated without charge.

Dr. Frank J. O'Brien, director, psychological clinic, Louisville, Ky., followed with a discussion of Dr. Alford's paper. He pointed out that in a general hospital a patient suffering from physical disease many times shows mental symptoms as well which need treatment. The favorable convalescence of a patient in particular depends upon his own mental attitude and that of those about him. Social workers are particularly interested in prevention, and so attack the points in the environment which cause or precipitate mental disturbance. And because of their interest in prevention work with children appeals to them particularly.

Mrs. May D. Ballou, psychiatric social worker, City Hospital, Indianapolis, Ind., continued the discussion by giving an account of the work of the psychopathic ward which has been established in connection with the city hospital of Indianapolis. The Indianapolis Foundation has made possible her services as psychiatric social worker attached to that ward, and her work began in April, 1925. The need for social case work in connection with such a ward is revealed by the report of the first six months the ward was in operation, January 1 to July 1, 1925. Out of 183 patients treated, 76 were returned to the community. Mrs. Ballou conceives her responsibility as threefold—to the patient and his family, to the physician, and to the community. She presented three cases illustrating these three fields of responsibility.

"What information can you give me about organizing a social service department and what sort of work do you do?" was a question frequently asked at the booth of the American Association of Hospital Social Workers.

The answer to this question was found in the exhibit on display in the booth which portrayed graphically various phases of medical and psychiatric social work. There were a number of telling posters showing the interrelationship of medical and social treatment and the many types of service that can be rendered by the social worker.

The value to a hospital of a social service department was demonstrated in one poster that enumerated a few of the many services the department can render in the way of remedying the undesirable home conditions that so often prevent medical treatment from being effective. It showed the part the social worker plays in helping the patient to carry out the doctor's recommendations and the assistance she can be in securing convalescent or sanitarium care.

In contrast to this general statement of the functions of social service was a poster depicting the social treatment in one case, that of a diabetic girl, who through failing eyesight, illness and discouragement had gone down, step by step, until she could go no further. The other side of the picture shows how she is brought back to a normal, healthy life by the social worker who, at the request of the physician, pays for the necessary insulin, arranges vocational training and finally finds suitable employment.

Still another poster showed the effectiveness of follow-up in the case of a family with venereal disease, and two others showed the work done in cardiac and pediatric clinics. An effective chart showing the organization of a social service department and its relation to the hospital was of particular interest to executives.

The work in the child guidance and mental hygiene clinics was demonstrated in a series of posters which were all the more striking because of their simplicity. Bad environment and faulty training were shown to be responsible for most behavior problems. One clever drawing of a very rueful little boy was entitled, "Don't spank him, see the doctor."

The table exhibit afforded material of real value for those who wished to study in detail the organization of other social service departments. There were several pamphlets dealing with the organization and scope of work in various clinics, which were of great interest both to doctors and social workers, as were also the sample forms and blanks used in different hospitals and dispensaries. Mention should also be made of the case records, two of which had been awarded prizes in a recent competition, and of the special studies that had been made of certain groups of patients.

The departments that contributed to the exhibit are scattered all over the country and each department is in a way unique. Each has a particular contribution to make and an opportunity to be of real assistance through this interchange of ideas.

The Hotel Dieu of Lyons, was founded in 542 by Childebert I., at the solicitation of Archbishop Sacerdos. This hospital (xenodochium) was under the supervision of laymen. It was not turned over to the clergy until six hundred years later (1308).

OCCUPATIONAL THERAPISTS HOLD FOURTH ANNUAL MEETING WITH A. H. A.

Reported by T. B. Kidner, President,
American Occupational Therapy Association, New York

THE annual meeting of the American Occupational Therapy Association was held for the fourth year in succession in conjunction with the meetings of the American Hospital Association and attracted a large attendance of members.

The committee on local arrangements made excellent preparations and proverbial southern hospitality was extended to the members. Miss Mary Louise Speed, director of occupational therapy, Louisville City Hospital, Louisville, Ky., was chairman of the committee and was ably assisted by the officers and members of the Kentucky Occupational Therapy Association and by the local hospitals.

The board of managers met on Monday, October 19, and an important meeting was also held on that day of members interested in training school problems and standards.

Tuesday morning was given over to reports of the year's work. Mrs. Eleanor Clarke Slagle, secretary-treasurer of the association, reported an exceedingly busy year for the national headquarters' office. One hundred and seventy new members were admitted during the year, and many requests for information and advice have been dealt with by the officers. The placement service has secured positions for a large number of members. Special literature has been prepared and distributed and the interest in curative occupations for all types of illness and disability has greatly increased.

T. B. Kidner, president American Occupational Therapy Association, and Mrs. Frederick W. Rockwell, New York, chairman, finance committee of that association, Philadelphia.

The standing committee on research and efficiency, chairman, Beatrice Lindberg, St. Paul, Minn., submitted a report on a program of work for state and local associations.

The standing committee on installations and advice submitted a progress report of its analysis of various crafts as to their suitability for curative purposes. This was in continuation of the excellent report on materials and equipment presented at the 1924 meeting.

The committee on publicity and publications, chairman, Dr. W. R. Dunton, Jr., Catonsville, Md., reported that the name of the official organ had been changed from *Archives of Occupational Therapy* to *Occupational Therapy and Rehabilitation*, and also submitted an offer from the publishers of a special group subscription rate. The meeting, therefore, resolved to recommend to the board of managers that the membership dues be increased to include the cost of the official organ of the association.

The committee on teaching methods, chairman, Marjorie B. Greene, Boston School of Occupational Therapy, Boston, presented some important recommendations with regard to the inspection and standardization of training schools and the registration of properly qualified occupational therapists, and it was resolved to appoint a special committee to draw up a scheme for presentation at the next annual meeting.

The committee on finance, chairman, Mrs. Frederick W. Rockwell, Philadelphia, reported considerable progress in raising a special fund for the employment of a full-time office secretary. The report was received with enthusiasm by the members. Pledges were made from the floor by individual members and on behalf of state and local associations and the amount aimed at by the finance committee was practically reached.

The formal public opening took place on Tuesday afternoon. A solemn invocation was pronounced by Rev. A. L. Powell, Louisville. James C. Pearson, Louisville, president, Kentucky Occupational Therapy Association, then gave an address of welcome, which was replied to on behalf of the board of managers, by Mrs. F. W. Rockwell. T. B. Kidner, president of the association, followed with the annual presidential address, in which he reviewed the accomplishments of the association, and outlined various opportunities and needs for increased service. As in previous addresses, Mr Kidner stressed the need of high standards of training and work, and urgently advocated the establishment of a national register of properly qualified workers. He cited various proofs of the increase of interest in occupational therapy and of its application in and out of institutions. He said the association felt particularly gratified on being asked to provide a speaker on occupational therapy for one of the sessions of the American Hospital Association. This task was undertaken by Dr. John D. Adams, Boston, Mass., who presented an able and masterly paper on "The Present Status of Occupational Therapy in our Hospitals." President Kidner also outlined some subjects of research that should be undertaken by the association, and paid high tribute to the work already done in this direction by the standing committees. He also spoke of the great debt owed by the association to Mrs. Eleanor Clarke Slagle, secretary-treasurer, for the untiring and devoted service freely given by her to its affairs. Her work has been chiefly responsible for the growth and success of the association.

Louise C. Morel, chairman of public welfare, Kentucky Federation of Women's Clubs, spoke on the cooperation of women's clubs in extending the knowledge of occupational therapy.

An exceedingly interesting account was then given by Natalie Brush, president of the Junior League of Indianapolis, on the work of the curative workshop maintained by the league in the James Whitcomb Riley Memorial Hospital for Children. In the unavoidable absence of Miss Brush, the paper was read by Winifred Conrick, director of the workshop. The discussion was led by Hilda Goodman, head of the Junior League Curative Workshop in Milwaukee, Wis., who illustrated her remarks with diagrams and samples of special apparatus developed in the workshop in Milwaukee.

On Tuesday evening, an informal reception was given to the presidents of the state and local associations, which now number seventeen in the United States, and two in Canada. Two new state associations were formed during the year—Connecticut and Iowa.

Occupational therapy in tuberculosis formed the subject for discussion on Wednesday morning, when several excellent papers were presented. Mrs. Gertrude Sample, U. S. Veterans' Hospital, Oteen, N. C., was section chairman. Beatrice Lindberg, director of occupational therapy, Minnesota Sanatorium Advisory Commission, presented a well thought out paper on "The Sale of Occupational Therapy Products without Commercializing the Department." The development and aims of the Potts Memorial Hospital Project, Livingston, N. Y., were described by the director, Dr. H. A. Pattison, who said it is to be an institution where "industrial convalescence" will be provided for arrested cases of tuberculosis. Dr. Oscar O. Miller, medical director, Waverly Hill Sanatorium, Louisville, Ky., read a very interesting paper on "Work for the Tuberculous, During and After the Cure." The discussion that followed the paper was led by Edward Hochhauser, of the Altro Manufacturing Co., the well-known factory for ex-sanatorium patients in New York.

One of the most effective of the educational and scientific exhibits was that of the American Occupational Therapy Association containing work done from O. T. departments in various hospitals of the country.

The officers and members of the association were guests at luncheon of the City Hospital on Wednesday, and in the afternoon the association met in joint session with the Women's Club of Louisville, in their fine club house. The session was devoted to the subject of occupational therapy in mental diseases, and was opened by a short address from Mrs. Eleanor Clarke Slagle, who told of the advances made in the use of occupational therapy, physical exercises and recreation in the hospitals of the New York State Hospital Commission, of which she is the director of occupational therapy. Each of the fourteen hospitals under the commission has a well organized department of occupational therapy (including physical exercises and recreation) and over 10,000 patients are at present being given curative work on prescriptions of the hospital physicians.

Dr. William Tiffany, clinical director, King's Park State Hospital, Long Island, N. Y., presented a valuable paper on "Hospital Records: What May the Medical Officer Expect from the Occupational Therapist Dealing with Mental Patients?" Dr. Tiffany described the special lectures given to the occupational therapists in his hospital in connection with the "Narrative Sheet," on which the occupational therapy worker records the reactions and behavior of patients in the occupational therapy work in the wards or in the special center.

Dr. M. A. Bliss, St. Louis, Mo., gave an inspiring and helpful paper on, "Handwork in Occupational Therapy for the Insane; Its Relation to other Factors of Therapy."

An interesting paper was given by Louis J. Haas, head of the men's division of occupational therapy, Bloomingdale Hospital, White Plains, N. Y., on the need for high standards in prerequisites for entrance for persons who undertake training for work with mental patients.

After the business of the session, the members were entertained by the women's club at afternoon tea.

Curative work for crippled children and work for the home-bound, were the topics dealt with on Wednesday evening. Marion Clark, University Hospital, Ann Arbor, Mich., was section chairman on work for crippled children, and an interesting discussion took place.

Mrs. A. P. Barnes, president, Duluth Occupational Therapy Association, Duluth, Minn., was section chairman on work for the home-bound, and an exceedingly interesting paper was presented by Martha Emig, director of occupational therapy, Duluth, Minn., who described the work being done in that city and its neighborhood for cripples and sick persons who are confined to their own homes.

At the Thursday morning session, the topic was "Occupational Therapy in General and Orthopedic Hospitals." The section chairman was Alberta Montgomery, Walter Reed General Hospital, Washington, D. C.

A thoughtful and scholarly paper on "The Vocational Aspect of Occupational Therapy," was presented by Dr. Harry J. Lefauver, U. S. Veterans' Bureau, Washington, D. C.

Major George F. Lull, Army Medical Center, Walter Reed Hospital, Washington, D. C., read a most interesting and valuable paper on "Occupational Therapy and its Relation to General Hospitals," and showed that it has a very definite and useful place in such hospitals.

The record of an interesting and significant project for the post-hospital care of patients was described in a thorough and helpful way by Raymond Greenman, Rochester and Monroe County Public Health Association, Rochester, N. Y., whose paper was entitled "Developing Rochester's Community Curative Workshop."

In view of the great and increasing attention now being paid to diseases of the heart, a very timely, scholarly and, albeit, practical paper was presented by Dr. W. D. Stroud, instructor in cardiology, University of Pennsylvania Graduate School of Medicine, Philadelphia, on "Occupational Therapy in Diseases of the Heart."

The use and exceedingly great value of properly applied curative work in orthopedic cases was dealt with by Dr. John D. Adams, Boston, in his closely reasoned and valuable paper on "Occupational Therapy in Orthopedics." Dr. Adams spoke of the absolute necessity for the proper training of O. T. workers who are to deal with orthopedic cases, and said he had found occupational therapy to be a very valuable and well-nigh indispensable adjunct for that type of case.

Occupational therapy and rehabilitation formed the subject of discussion on Thursday afternoon; the section chairman being Miss Kathryn Root.

Walter I. Hamilton, Personnel Department, Boomer-du-Pont Properties, Inc., New York, presented a valuable

and suggestive paper on "The Problem of the Ex-Patient," and outlined in detail the manifold factors involved in after-care, including curative work, vocational rehabilitation and placement.

The scope and possibilities of the U. S. Industrial Rehabilitation Act, were fully described by John A. Kratz, chief of the industrial rehabilitation division, Federal Board for Vocational Education, Washington, D. C.

At the business meeting, the retiring president, T. B. Kidner, was unanimously re-elected.

For vice-president, Dr. M. A. Bliss, St. Louis, Mo., was the unanimous choice of the members. Mrs. Eleanor Clarke Slagle was unanimously re-elected as secretary-treasurer.

Vacancies on the board of managers were filled by the re-election of Mrs. Elias Michael, St. Louis, Mo., and the election of Dr. John D. Adams, Boston, Mass., and Dr. Oscar O. Miller, Louisville, Ky., each of whom will serve for three years.

The annual banquet concluded the meetings of the convention and proved to be, as always, a delightful function. The principal guest of honor, Dr. Charles A. Prosser, director, Dunwoody Institute, Minneapolis, Minn., delivered an inspiring address on "The Place of Occupational Therapy in the Field of Rehabilitation."

R. K. Atkinson, of the Russell Sage Foundation, New York, gave a helpful and practical address on "Organized Recreational Features in all types of Hospitals." The president of the association acted as toastmaster, and brief addresses were made by the newly-elected directors and by Dr. McCormick, Kentucky State Board of Health, Dr. Barnett Owen, Louisville, and James C. Pearson, of the Kentucky Occupational Therapy Association.

Throughout the sessions Mrs. Louis J. Haas ably presided at the piano for the community singing with which most of the sessions opened. As in previous years the community singing was a much enjoyed feature of the banquet.

On Friday morning, by invitation of the women's advisory board of the Waverly Hill Sanatorium, a party of members especially interested in occupational therapy for the tuberculous visited this institution and saw the interesting work being done in the occupational therapy department by Mrs. Draffin. The visitors were also entertained at a luncheon given by the women's advisory board.

MEETING OF AMERICAN PUBLIC HEALTH ASSOCIATION

IN point of attendance and quality of program, the fifty-fourth annual meeting of the American Public Health Association, held at St. Louis, October 19 to 22, measured up to previous meetings. About a thousand health officers and sanitarians were in attendance during the four days, and the discussion largely reflected the program of public health work during the past year. There were no outstanding announcements of new discoveries or methods, but many of the unsolved public health problems were given serious consideration.

Out of the meeting sentiment crystallized by resolution in favor of unification of all federal health activities into one department under the immediate supervision of an assistant secretary. Another resolution favored the repeal of laws, now in effect in many states, requiring at least thirty cubic feet of fresh air per minute per child to be supplied to schoolrooms. Past studies have shown that window ventilation with exhaust ducts in or near ceilings for removal of vitiated air gives more satisfactory results at greatly reduced costs.

The need for trained sanitarians was discussed by Dr. J. A. Ferrell of the International Health Board, New York. He estimated the number of health officers needed in this country to be 7,000, of which 1,300 were available, and the number of public health nurses as 15,000, of which 6,000 were available. The number of trained health officers graduated each year from schools of public health in the United States and Canada is only 100. This number would need to be increased to approximately 600 a year to meet the present needs for trained health administrators. Approximately 1,000 public health nurses are also needed each year to make up the present efficiency in the next decade.

In the vital statistics section, substantial progress was made towards the inclusion of the entire United States in the registration area. When this is accomplished it will be possible for the first time in public health history to obtain accurate and comprehensive records on vital statistics.

Sessions devoted to child hygiene were well attended and evoked spirited discussion.

The possibility of carrying infection into the home by visiting nurses engaged in infant and child welfare work was ably discussed by Marguerite A. Wales of the Henry Street Nursing Service, New York. Miss Wales reported that an exhaustive study of this question failed to reveal any evidence tending to incriminate the nurse.

Doctor Fronczak, health commissioner of Buffalo, N. Y., stated that in his opinion health departments were justified in extending free service to certain impoverished citizens in the fields of industry, child hygiene, nutrition and posture. Such service did not encroach upon the field of the private physician, but rather aided him, in that many persons able to pay medical fees would become interested in these questions through the publicity given to the health department's work.

If funds become available the association is to undertake an enlarged program of activities, the first of which will be the organization of three regional offices to supplement the main office in New York. These will be located in the southeast, southwest, and northwest sections of the United States. These regional offices will keep in close touch with public health problems in their various territories and will assist health departments in increasing the value of their work wherever possibile. Assistance will be rendered commercial and other organizations in the solution of their problems. It is proposed to raise the increased budget by obtaining from municipalities—particularly through their health departments, community chests, chambers of commerce, civic clubs and other means—subscriptions in proportion to the size of the community.

Two meetings are to be held next year—one in Atlantic City in May in cooperation with the American Health Congress, and the regular annual meeting at Buffalo, N. Y., in October. Professor C. E. A. Winslow, professor of public health, Yale University, and member of the consulting board of the *Nation's Health*, was elected president.

VARIOUS PHASES OF DIETETICS DISCUSSED AT COUNCIL MEETING

THE program of the Hospital Dietetic Council, given on October 19, 20 and 21 was of great interest to all whose vocations bring them in contact with problems of nutrition.

Dr. Arthur T. McCormack, Health Officer, Louisville, Ky., delivered an address of welcome and expressed appreciation of the fact that rational dietetics is becoming an influence throughout infancy, childhood, and adult life.

Florence Busse, Iowa State Agricultural College, Ames, Iowa, gave in detail the methods pursued in training young women for hospital dietetics. In all cases they are selected carefully, she stated, with a view to their practicality, efficiency, leadership and academic training. In return a square deal should be granted on the part of the hospital which allows them to function as student dietitians.

Rev. F. O. Barz business manager Bethesda Hospital, Cincinnati, gave a paper on "The Hospital Buyer." A dietitian must keep abreast of the times. She must show her progress by the continual improvement of her service to the patient. The budget should be watched and every effort made toward economy. There are a few underlying principles that should govern the hospital buyer. First, determine what you need before you buy; second, know how much you have on hand; third, know the cost of supplies in order to make intelligent comparisons; fourth, pay your bills promptly, and receive your discounts; fifth, be up to date with equipment but watch your budget.

A central storeroom with central control is an absolute necessity, according to Mr. Barz. Supplies should leave the store only by a system of rigid requisitions. Care should be used in buying futures in canned goods. Do not abolish certain articles entirely, but buy cautiously and use cautiously.

Dietitian's Place Defined

The next paper entitled "The Place of the Dietitian in the Hospital Organization," was given by Dr. Joseph C. Doane, medical director, Philadelphia General Hospital, Philadelphia, who said that the duties of the dietitian are so many and so varied that it would require a super-woman to perform them. The salaries paid to dietitians do not generally seem commensurate with the number and the importance of the duties involved. The hospitals of the country spend annually $185,027,318.40 for food—an amount important enough to demand well planned workrooms, with the best possible facilities for light, air and sanitation.

Successful administration demands that the dietitian should be definitely responsible to the hospital administrator, should be able to fill diet prescriptions and should have the power to administer her own department without the aid of the many members of the hospital family. Dr. Doane believes that the dietitian should visit the markets in order to keep in touch with current commodities and prices. He believes also that she should be known among physicians and interns and that her training in food enables her to render a distinct contribution to the scientific treatment of many patients. She should strive to create in a physician's mind a respect for her skill, in order that he may take advantage of her ability to assist him in the dietary treatment of certain diseases. Last but not least, the dietitian can raise the hospital morale by feeding doctors, interns, nurses and orderlies an adequate and nourishing diet.

Economy was the subject of a paper by Irene Wilson, Homeopathic Hospital, Pittsburgh, read at the afternoon meeting. Miss Wilson suggested several ways of preventing waste such as using a butter cutter and sending to each floor the required number of pieces; using selective menus in order to serve the kind of bread desired; seeing that milk bottles are turned back and forth to thoroughly mix the cream; sending out the sugar in envelopes; making careful use of canned goods and inspecting garbage. A few suggestions for reducing expenditures were made, such as using celery tops for flavoring instead of celery stalks; substituting oleo for butter in cooking; giving skim milk plus 20 per cent cream for employees instead of whole milk. Each dietitian must be an individual student of her own problems and work out what she conscientiously feels is economy in her own particular hospital and under her own peculiar conditions.

Types of Equipment

Marion Peterson, Miami Valley Hospital, Dayton, Ohio, spoke concerning types of equipment for different sized hospitals. The choice of equipment for hospitals large or small depends upon several factors, first, the lay-out of the kitchen, second, the amount of money available, third, the nearness of the supply house to the hospital and fourth, the type of service given. There are so many kinds of equipment on the market that it is well to look carefully into the various makes before deciding, considering carefully the advantages and disadvantages of each. If equipment could be standardized by a central bureau it would be of great benefit to dietitians who are starting out to equip new kitchens.

Bertha E. Beecher, Christ Hospital, Cincinnati, spoke on the necessary personnel of a dietary department. The personnel needs of a dietary department are as diverse as are hospitals, dependent upon the type of service, the kind of equipment, the ideals relative to food, and the rest and recreation of employees. There are three things essential in keeping the number of employees at the lowest figure without crippling the efficiency and speed of the department: cooperation, training the help to do several things well, and a regulation that an employee report by telephine one-half hour before he is expected on duty should he be unable to work. The plan of giving employees one rest day per week has proved satisfactory.

On Tuesday morning the program was opened by Dr. M. G. Peterman, Mayo Clinic, Rochester, Minn. Dr. Peterman discussed the ketogenic diet which he has used with great success in the treatment of epilepsy.

Dr. Peterman considers this diet as one where the dietitian has an opportunity to exhibit her skill for it requires a great deal of study to conceal the large amount of fat in such a way that the diet is not repugnant to the patient.

The next paper on "Maintenance Diets, With Variations," was given by Minna Roese, Mount Sinai Hospital, New York. There are various ways of working out maintenance diets, she said. The following points should be kept in mind: first, a mastery of food values so that the figures and approximate amounts are at once visualized; second, it is important to know your patient, his nationality, and the food habits of his race; third, it is essen-

tial to know the principles of treatment for each diagnosis and the articles of food used.

The discussion was led by Mary M. Harrington, Ann Arbor, Mich., and stired up response from many members.

The "Dietitian and the Steward" was the title of the paper by Ruth Bowden, Cottage Hospital, Santa Barbara, Calif. The work of the dietitian according to Miss Bowden has embraced so many phases of the food problem including buying, store-keeping, menu planning, employing the help, supervising the cleaning, teaching of nurses, and planning special diets, that she finds it difficult to do a satisfactory piece of work from her own point of view. In some hospitals it has been arranged for a steward to do the buying, store-keeping and supervision of food service for the well, leaving the dietitian to take charge of the food for patients and teach the subject of food and nutrition to the nurses. This plan has proved successful in some instances where a competent steward has been available.

The Teaching Phase of Dietetics

Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, read a paper by Dr. W. H. Olmsted on teaching dietetics to medical students. Those interested in dietetics cannot but be impressed by the ignorance of the average general practitioner on these subjects. At Barnes Hospital the teaching of dietetics to medical students and interns begins in the student's third year, and consists of lectures and demonstrations. Following a general review of physiology and biological chemistry the intern is introduced to the dietitian of the hospital and her department. He sees the preparation of the diets in the form of three meals for a prospective patient. The student gets an idea of the quantities required and the application of the diet to the individual patient according to the points brought out by the instructor in her lectures on the usage of all types of food that make up the special diet. In the fourth year of the medical student the clinical clerk and the instructor discuss with the patient the diet that he is taking. The dietitian is present at these hospital rounds.

"Metabolism and Diet in Disease," was discussed by Max H. Hoffman, Charles T. Miller Hospital, St. Paul, Minn., who said in part:

"Knowledge of metabolism is essential in treatment of thyroid disorders, diabetes mellitus and disturbances of nutrition. Basal metabolism is secured by having the patient rest from one-half hour to one hour, and abstain from food twelve to eighteen hours. The basal rate is a very constant figure in a group of the same age and sex.

"At times it is a difficult thing to give every sick patient a high calorie diet, but in these cases, the skill of the dietitian and the nurse will work wonders."

Papers were also given by Mary A. Foley, Kahler Corp., Rochester, Minn., on "Essential Knowledge of Applied Dietetics for the Hospital Intern" and by Dr. C. W. Dowden, West Baden, Ind., on "The Dietetic Treatment of Gastro-Intestinal Conditions."

The business meeting was conducted on Tuesday afternoon. Proceedings of the year and reports of committees were heard and discussed. At the meeting of the executive board, held in March, 1925, the question of financing the magazine, *Dietary Administration and Therapy*, was discussed. Owing to the fact that funds were needed for the expenses incurred in publishing and maintaining this project, and that the members of the Hospital Dietetic Council were laboring under a burden, not entirely their own, it was voted to organize a company, the holders of stock to consist of people desiring to further this movement.

A motion was carried directing that action take place immediately and that incorporation should be effected as soon as the necessary amount of shares was subscribed for. Each member of the committee pledged activity in securing subscriptions to the stock. By May 1 the desired amount was raised and even a surplus was subscribed. Incorporation was then effected under the laws of the State of Ohio. The bill of sale was presented to the council transferring the magazine, *Dietary Administration and Therapy*, together with its assets and liabilities to the stock company, D. A. & T., Inc. Said bill was duly approved and left for signatures of president and executive secretary to be affixed.

Election of officers and appointment of committees was the final proceeding of the business meeting. Results of the election ware as follows:

President, Rena S. Eckman, Michael Reese Hospital, Chicago; first vice-president, Bertha M. Wood, Mount Sinai Hospital, New York; second vice-president, Mary A. Foley, Kahler Corporation, Rochester, Minn.; new member of the executive board, Mary M. Harrington, University Hospital, Ann Arbor, Mich., to take the place left vacant by Margaret Drew, resigned on account of ill health. Mrs. Dorothy A. Loudon, Agricultural Hospital, Fargo, N. D., and E. M. Geraghty, Lakeside Hospital, Cleveland, were elected to serve two years.

Committees for the year were then appointed.

NURSING SECTION WELL ATTENDED

THE attendance at the sectional meeting devoted to nursing was so large that many of those who wished to hear the speakers were turned away from the main hall which was the room allotted to the meeting.

The session was held Wednesday evening and the program was of unusual worth. Many of the leading authorities on nursing problems were present and the discussions that followed each paper were illuminating and emanated from reliable sources. Miss Sally Johnson of the Massachusetts General Hospital, Boston, acted as chairman and Miss Alice Gilman, State Board Nurse Examiners, Albany, N. Y., was the secretary.

"The Grading of Schools of Nursing" was the first paper on the program and was presented by Miss Laura Logan, R.N., dean, Illinois Training School for Nurses, Chicago.*

The paper aroused much interest and was discussed by Dr. Louis H. Burlingham, superintendent, Barnes Hospital, St. Louis, Miss Mary M. Roberts, editor of the *American Journal of Nursing*, Dr. Malcolm MacEachern, American College of Surgeons, Chicago, and Dr. S. S. Goldwater, Mount Sinai Hospital, New York.

Bertha M. Allen, R.N., superintendent, Newton Hospital, Lower Newton Falls, Mass., presented a paper entitled, "How Can Schools of Nursing Located Away from Centers of Population Attract Suitable Applicants?" Many nurses and supervisors discussed this question, the consensus of opinion being that if the proper living conditions and the proper recreational conditions were obtainable the right sort of girls would avail themselves of the school.

Miss Janet Geister, Committee on Dispensary Development, New York, presented the report of the National League of Nursing Education, entitled "Opportunities for Student Nurses in Hospital Dispensaries." This report was discussed by Michael M. Davis and others who were present. The report appears in abstract on page 452.

*The paper will be printed in full in a later issue of THE MODERN HOSPITAL.

ENTHUSIASM PERVADES SESSIONS OF PROTESTANT HOSPITAL ASSOCIATION

AN UNUSUAL interest in the problems of church hospitals and in ways of promoting greater cooperation between the various denominational hospitals was evidenced at the sessions of the fifth convention of the American Protestant Hospital Association held at the Seelbach Hotel, Louisville, October 17, 18, 19.

Throughout the sessions there was a record attendance of members who were eager to bring the problems of their individual hospitals before the conference and to exchange views on the various angles of hospital service. This was particularly true of the round tables which became marts where ideas on all phases of administration, ethics, publicity and other timely subjects were freely exchanged. The topics for discussion emanated from the persons present. This method for conducting the discussion succeeded in bringing to light the most practical everyday points of procedure and an added enthusiasm from the members present.

The registration for the convention showed more than two hundred members from every part of the United States in attendance. Nearly all of the various Protestant denominations were represented, with a delegation of six from the Salvation Army.

Group Reports Feature Meeting

One of the interesting features of the convention was the group reports from the various denominations present. The members of each denomination held a brief meeting during the convention and gave progress reports at the closing meeting. These group meetings resulted in definite contributions toward the progress of the association. One of these groups suggested that the association place more emphasis upon the value of its work and membership to all members of the Protestant churches who are engaged in hospital work. Heretofore, many people have believed that the association existed only for those who are connected with denominational hospitals. It was also suggested that the word sectarian be discontinued and the term denominational be used instead in classifying the various institutions.

Davis Re-elected President

At the closing session, the Rev. N. E. Davis, executive secretary, Board of Hospital Homes and Deaconess' Work of the Methodist Episcopal Church, Chicago, was unanimously re-elected president for the coming year. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, was elected president-elect, and J. H. Bauernfeind, superintendent, Evangelical Deaconess Hospital, Chicago, vice-president. Heretofore, the association has not had a president-elect, but it was deemed wise by the convention to create this office in order to prepare the coming president for his office.

Dr. Frank C. English will continue to serve the association as secretary-treasurer.

The trustees for the coming year are Alice Thatcher, superintendent, Christ Hospital, Cincinnati; B. A. Wilkes, superintendent, Baptist Sanitarium, St. Louis, Mo.; A. C. Cree, Baptist Hospital, Atlanta, Georgia; L. C. Reynolds, superintendent, Methodist Hospital, Los Angeles, Calif.; and Mrs. C. E. Davis, Seattle.

The convention opened promptly at 9:45 Saturday morning, with devotions by the Rev. John L. Fort, D.D. of Louisville. Dr. Fort asked a blessing upon the assembled church and hospital leaders and set forth the virtues of the associations and its undertakings.

The Mayor of Louisville, the Hon. Houstin Quin, delivered an exceptional address of welcome. He outlined the work that the hospitals of the city had been doing and the public health work that was under way and told of the

A few delegates and speakers. (Left to right) Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland; John H. Olsen, Lutheran Hospital of Manhattan, New York; Joseph Purvis, superintendent, Scranton State Hospital, Scranton, Pa.; Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill.; Dr. Newton E. Davis, president, Protestant Hospital Association, Chicago; Dr. James T. Case, Battle Creek Sanitarium, Battle Creek, Mich., who gave a lecture on x-ray valuations; Dr. Frank C. English, secretary-treasurer, Cleveland; Dr. Malcolm T. MacEachern, Chicago, who delivered an address at the banquet session, and the Rev. H. L. Fritschel, president Milwaukee Hospital, Milwaukee, Wis.

future plan of the city administration and its policies.

H. F. Vermillion, superintendent, Southern Baptist Sanitarium, El Paso, Texas, responded to the welcome on behalf of the association and stated that it was banded together to promote the Christian hospital work of the United States. He told of the aims and ambitions of the organization and the steps that were being taken to promote better conditions among the hospitals in the various church groups.

Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, led the delegates in singing the national anthem and other songs of an inspiring character.

"You are God's Messengers of Health," declared Dr. Davis upon delivering his presidential address, following the other opening features of the program. Dr. Davis quoted some interesting figures on Protestant hospital growth in this country during the past few years and also told of the building programs that are now being worked out in many parts of the country. He urged the members of the various denominations to renew their already earnest efforts towards greater efforts in this noble work of administering to the sick.

Two prominent delegates from the South. (Left) Dr. Eugene B. Elder, superintendent, Georgia Baptist Hospital, Atlanta; (right) Dr. Arch C. Cree, Baptist Hospital, Atlanta, Ga.

Following his speech, Dr. Davis introduced to the delegates Dr. Malcolm T. MacEachern of the American College of Surgeons, Chicago, who was to be the speaker at the banquet later in the day; John A. McNamara, managing editor, THE MODERN HOSPITAL, and Matthew O. Foley, managing editor, *Hospital Management*, Chicago.

The first paper of the convention was read by E. E. King, superintendent, Baylor Hospital, Dallas, Texas. His topic was "The Best Methods of Relating the Denominational Hospital to the Organized Life in the Denomination." Mr. King brought up many points in his paper showing that there is a real reason for carrying on the precepts of Christ in the hospital work. He quoted several passages from the Bible in which the work that the hospital was doing proved to be an exemplification.

"Selling Hospital Service with Attractive Publicity," was the subject discussed by Dr. J. H. Bauernfeind. In answering the question, "What kind of publicity will best help a hospital?" Dr. Bauernfeind stated that there were many ways to promote good publicity but that the best was by gaining the good will of the patient, the community and the church. "Publicity should be inspirational," he declared, "and the best organization will soon cease to function unless there is continued inspiration in leadership."

Dr. Bauernfeind stated that the magazines devoted to hospitals were doing a great work and that their value should not be underestimated. He urged the delegates to send them items of interest from time to time.

Perhaps one of the most valuable features of the entire meeting was the round table led by Dr. C. S. Woods, superintendent, Saint Luke's Hospital, Cleveland. Many questions of vital importance were brought up for discussion. The ever-present problem of the church association and the board of trustees and the relation of both to the hospital was brought up. The size of the association, how it shall function and who shall make up its personnel was discussed from many angles.

"How Is the Laboratory Work Taken Care of in a 75 to 100 Bed Hospital?" also brought forth many viewpoints. The financing of the laboratory is carried on in so many ways that the opinions of those present were illuminating as well as instructive. One of the delegates stated that he had a part-time pathologist and a full-time laboratory technician who also did other work in the hospital and that a fee was charged for outside work. Another stated that he charged a flat rate upon admission and a special rate for extra work, such as Wassermann tests.

"Please Define Fee Splitting," proved to be best answered by Dr. M. T. MacEachern, who characterized it as any practice whereby a physician received a commission, fee, emolument of any kind or gratuity for work that he did not perform. He also stated that it was a hard matter to define fee splitting without leaving some loophole through which the unethical physician or hospital could not slip. He gave several examples of the evils of this pernicious habit and paid a glowing tribute to the stand that Dr. Davis has taken in the Methodist hospital group.

The afternoon session Saturday was filled with papers of unusual interest, the subjects on the program being divided between technical and nursing subjects. Dr. Davis opened the session with the appointment of committees, the report of the standing committees and by the report of the executive secretary, Mr. English. Following these reports the first paper was read.

Dr. Willard C. Stoner, Cleveland, Ohio, who has spent much time in Europe, told of his observations in that country and made a comparison of the work being done in this country and abroad. Dr. Stoner was a member of a group of five hundred physicians who toured the British Isles and the continent recently and visited many hospitals.

Organization of Pathological Laboratories

"The Organization and Development of Pathological Laboratories as Related to Standardization" was the title of Dr. R. S. Austin's paper. Dr. R. S. Austin is of the department of pathology of Cincinnati General Hospital, Cincinnati, Ohio.

"The establishment and maintenance of a general pathological laboratory in a small hospital present problems similar to those which would have to be solved by a large hospital, but some of these problems are more intensified for the smaller institution, notably the matter of laboratory space, laboratory personnel and the financing of the laboratory," he stated.

Each of the major issues were then taken up by Dr. Austin and carefully outlined.

Cornelia D. Erskine, R.N., superintendent of nurses, Louisville City Hospital, was the first speaker on nursing subjects during the afternoon. She discussed the question of "What Shall Be Our Future Educational Policy Regarding Nurses Entering Training?" and "How Shall the Schools Be Graded by the State?" The work attendant upon the training of nurses needed in most hospitals

at the present time and some of the vexing problems that are before hospitals were taken up and clearly defined and logical solutions were presented when it was possible.

Louise Renier, director of social service, Woman's Hospital in the State of New York, read a paper on "The Usual Problem Which Confronts Every Hospital." She stated that more than a century ago the physicians took surgery out of the barbershops and that now the physician was taking criminology away from the politicians and the lawyers. She told of the work that was being done toward more adequate care of the sick and the various agents that were carrying on this work.

Success of an unusual degree characterized the banquet that was held in the evening. The dinner courses alternated with songs and speeches. Dr. Davis presided and called for many interesting remarks from the diners. A rising count of the various denominations was one of the first proceedures. Many different denominations were present and loud cheering greeted every report. Robert Jolly led the singing and much enthusiasm was shown by the response to his good natured jibes.

The main address of the occasion was given by Dr. Malcolm T. MacEachern, representing the American College of Surgeons, who spoke on "Denominational Responsibility for Standardization." Dr. MacEachern set forth in definite terms the duties of denominational hospitals in cooperating with the standardization work of the college.

Another interesting feature of the session was an illustrated lecture on x-ray valuations by Dr. James T. Case, surgeon, Battle Creek Sanitarium, Battle Creek, Mich. The other addresses were "All Healing is Divine Healing," by Dr. C. C. Jarrell, Atlanta, Ga., and "Why the Protestant Hospital Has a Definite Place in the Hospital Field," by Dr. Eugene B. Elder, superintendent, Georgia Baptist Hospital, Atlanta, Ga.

The closing session was held Monday morning and prolonged until 1 o'clock in order that members might attend the A.H.A. convention in place of the scheduled afternoon session.

Ethical Science in Practice

One of the leading papers of the session, which was devoted largely to problems of general interest, was on the subject of "The Practice of Ethical Science in Hospital Relations," by the Rev. Thomas A. Hyde, Christ Hospital, Jersey City, N. J., who emphasized the need for better relations between all hospitals for the common good and brought out strongly the fact that the patient is the direct responsibility of the hospital and that thus far social agencies have been unable to lift the burden of adjusting the degree of charity service to which the individual case is entitled. This is yet a problem that the hospital must face in every instance, he said.

The subject of the responsibility of departmental supervisors was handled by the Rev. L. M. Riley, D.D., superintendent, Wesley Hospital, Wichita, Kan., who summarized his paper in the thought, "The chief function of executives is to create a favorable environment conducive to the best production in the departments and between departments." He warned superintendents and department heads to exercise their authority with care and discretion and referred to the editorial in the April issue of THE MODERN HOSPITAL, "Power, the Sharp Knife," to illustrate the two extremes of abuse of executive power.

In keeping with the intention of the association that an historical report be given from one denomination at each annual meeting, the report this year was from the Passavant Hospital group, by Sister Martha Pretzlaff, superintendent, Passavant Hospital, Pittsburgh, the oldest Protestant hospital in the country. Sister Pretzlaff traced the development of this hospital as well as of the other Deaconess hospitals of the country.

In her paper on the "Minimum Size and Relative Organization with Amount of Charity Permissible in a Self-Sustaining Hospital," Emily Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore., described the conditions existing in the small hospitals of the West and said that these hospitals were so situated financially that they could do but little, if any, charity work, but nevertheless were obliged to do a great deal of charity work, since the bulk of their patients were unable to pay even the minimum cost of care.

"Denominational Control and Interdenominational Cooperation" was the subject of a paper by the Rev. Edward F. Ritter, D.D., Robinwood Hospital, Toledo, Ohio, who outlined the advantages of denominational hospitals, in that they have fixed responsibility for success or failure in one body of experienced men and have an adequate and continuous income from the Church, and pointed out the ways in which the churches of various communities may cooperate.

The round table conducted by Robert Jolly proved to be one of the most interesting features of the closing session. One of the high lights of the discussion was on the subject of what degree of responsibility should be delegated to heads of departments. The concensus of opinion seemed to be that department heads should have complete control over their departments with authority to hire and fire employees under them. Other subjects discussed were whether children should be allowed to visit maternity departments and what should be done to nurses who were found smoking.

GUIDEPOSTS FOR THE INTERN

"Notify the visiting staff doctor promptly when a private or semi-private patient arrives in order that the doctor may know his patient is in the hospital and you can learn what orders are to be given for the patient," said Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, in a recent talk to his house and intern staff.

"Except in case of emergencies, routine work such as taking histories, physical examinations, and dressings should not be done in the wards after 5 o'clock at night, during meal hours, or the visiting hour.

"Except in emergency cases all preparations for operations should be written in the ward order book before 5 o'clock of the day preceding operation by members of the surgical staff.

"Transfers to or from surgery, should show the branch of surgery the patient is to be transferred to, or from. Always send through an inter-service transfer, that is, general surgery to gynecology, general medicine to neurology, use the regular transfer form for this.

"Patients discharged against advice are not ordinarily to be readmitted.

"Keep your critical list up-to-date. You should do this for the sake of the patients and their friends. It also aids in obtaining permission for autopsies. If there is a good reason the superintendent will be glad to restrict visitors to critical list patients on your recommendation. Aim to have a patient on the critical list at least twenty-four hours before death. On the other hand it should never be possible for a patient to come down to the front office for discharge while still on the critical list."

ADMINISTRATIVE PROBLEMS GIVEN PROMINENT PLACE ON A. D. A. PROGRAM

THE eighth annual convention of the American Dietetic Association, held in Chicago, October 12-15, proved to be the most successful ever held by the association. The speakers and the 450 members of the association present showed unusual enthusiasm, and the exhibits of food products proved interesting and instructive.

The meeting was opened by the president of the association, Dr. Ruth Wheeler, University of Iowa, Iowa City, who discussed the aims of the association, its work during the past year and some of its plans for the future. One of the objectives of the association for which there is an apparent need is to determine and to maintain standards. She expressed a hope that the association will soon set a higher standard for new members, because the more highly specialized and technical the work the more there is need for a broad foundation.

Dr. William H. Walsh, executive secretary of the American Hospital Association, Chicago, brought greetings from his association. In his discussion of the "Professional Standing and the Duties of the Dietitian in the Hospital," he said that her station was equal to that of the superintendent of nurses and her sphere of action should embrace the supervision of the selection, the inspection, the preparation and the service of all food. Her contact with the professional staff should be direct, since she is responsible for the execution of the physicians' orders on nutrition. He brought out the fact that even though there has been an ever-increasing number of hospital dietitians, the majority of the hospitals in the United States and Canada are still without them.

Reports from the city and state organizations throughout the country were given at the noon luncheon at which Kate Daum, Ph.D., department of nutrition, University of Iowa, presided.

The business meeting, held Monday afternoon, was given over in part to the discussion of the constitution, and some important amendments were made. The following officers were elected for the ensuing year: President, Ruth Wheeler, Ph.D.; vice-president, Dorothy Stewart, University of Michigan Hospital, Ann Arbor, Mich.; second vice-president, Florence Smith, St. Mary's Hospital, Rochester, Minn.; secretary, Katherine Fisher, director, Good Housekeeping Institute, New York; treasurer, Theresa Clow, Y. W. C. A., Chicago.

There was an unusual large attendance at the banquet on Monday night. The developments in the fields closely allied to dietetics were ably presented. Katherine Blunt, Ph.D., University of Chicago, reviewed the history of the home economics movement and indicated the present tendencies in that field.

The field of medicine in its relation to dietetics and hospital administrations was discussed by the following speakers: Dr. Ernest Irons, dean, Rush Medical College, Chicago; Dr. C. C. Burlingame, Columbia University and Presbyterian Hospital Medical Center, New York; Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago; E. A. Fitzpatrick, director, College of Hospital Administration, Marquette University, Milwaukee, Wis.

E. S. Gilmore, president, American Hospital Association, and superintendent, Wesley Memorial Hospital, Chicago, opened the program of the administration section, Tuesday morning. He suggested that the diet kitchens be centrally located and that a central tray service was feasible in small hospitals but questioned its success in larger institutions. He cautioned the dietitian to guard herself against spending too much time over insignificant details and thereby overlooking the big, constructive policies.

In his opinion, the steward should do the buying, employ the kitchen help, as it is a waste of the dietitian's time to have to take care of these details when her knowledge and training are needed for the supervision of special diet work, teaching and other important matters.

Delegates at the eighth annual convention of the American Dietetic

He urged dietitians to conduct their departments in the way which would produce the best results and in order to do this, he said, they must stay in one institution longer, since changing from one hospital to another, as too many hospital dietitians are doing, is not conducive to achievement, but to chaos.

In regard to the economy of food, he felt that some dietitians make the mistake of believing that economy consists primarily in the utilization of left-overs which are often unpalatable and as such their use is not economy.

"Practice economy before the food gets to the patients," said Mr. Gilmore, "and vary your menus and serve a good quality of food if you are to be successful in the management of your department."

The results of the study of the administration section were presented by Elizabeth Whittaker who brought out the importance of the dietitian's having full control of her department instead of being a mere menu planner and of permitting the steward and the department to run her.

She outlined the essentials of a budget under the following heads: investment, maintenance, food, salaries, variable wages, office expenses, and miscellaneous expenditures.

"I believe any man is willing to acknowledge that women's cooking is best in the home, in the morning and at night. If that is true why shouldn't it be best at noon downtown or in the hospital?" asked Myron Green, former president, National Restaurant Association. He voiced the opinion that women will be the salvation of the eating business, as executives as well as cooks, chefs and servants.

Mr. Albert Bridges, Chicago, representing the distributor, gave some valuable suggestions in regard to the standards by which canned goods may be judged. He said: "The clever salesman and the clever house will build its business on quality and quality only."

On Tuesday afternoon the much discussed and popular subject of obesity was analyzed from every angle, Dr. A. J. Carlson, University of Chicago, discussed the subject from a physiological standpoint and explained the influences of such factors as the endocrines, heredity and nervous instability on obesity, saying that they all must be considered in attempting to explain the cause of obesity. Dr. H. H. Fellows of the Metropolitan Life Insurance Company and Cornell Medical School, New York, reported results of three years work on obesity cases. Dr. Chi Chi Wang and Dr. S. S. Straus gave a report, with illustrations, of the work done at Michael Reese Hospital, Chicago. Dr. Arthur Cramp, director, bureau of investigation, *Journal of the American Medical Association*, Chicago, exposed the many so-called cures for obesity as nothing more than fakes and money extractors.

The Wednesday morning program consisted of two sections—dietotherapy and social service. The dietotherapy program dealt with the work done during the past year in various diseases.

Lydia Roberts, University of Chicago, spoke on the social service section program. She explained the organization and purpose of the nursery school that has been established in connection with the University of Chicago. The children in the school are from two to five years of age. A lunch is served that is planned and executed by the university students under the direction of Miss Roberts, with the aim of solving the nutrition problems of pre-school children. Mrs. Mary Swartz Rose, New York, reported that a nursery school is being planned to be opened soon in New York; she also spoke of the establishment of a well child nutrition service.

The members of the education section who have worked during the year on two definite problems, first, that of planning courses for the student dietitian and second, the accrediting of hospitals for student dietitian training, had some definite information to offer.

The last session of the convention dealt entirely with the importance of diet in the treatment of gastro-intestinal disturbances. These valuable contributions to the treatment of gastro-intestinal disturbances will be published in the *Journal of the American Dietetic Association.*

The speakers of the evening were: Dr. A. B. Luckhardt, University of Chicago; Dr. Milton Portis, Rush Medical College, Chicago; Dr. Donald P. Abbott, Rush Medical College, Chicago and Dr. H. H. Fellows, Cornell Medical College, New York.

Association, Edgewater Beach Hotel, Chicago, October 12-15.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, M. A.,
Butler Hall, 402 West 119th Street
New York

FINLAND WARMLY WELCOMES THE NURSING PROFESSION*

By Ethel P. Clarke, Director, Training School for Nurses,
Indiana University, Indianapolis, Ind.

IT IS difficult to write down impressions of a week that was so filled with varied delights. From the time that our boat touched the dock until we left again we were surrounded by the most gracious hospitality, organized in a marvelous way. This hospitality was extended not only by the president, Baroness Mannerheim, and the nurses, although they, of course, were the moving spirits, but by the government, the municipality, numerous organizations, and the citizens who so generously opened their homes and gave of their time and service in countless ways.

Members of the Nurses' Association of Finland wear a smart outdoor uniform of gray, and a round hat draped with a dark blue veil. Almost immediately the visiting nurses learned to look upon them as sources of help and guidance when in any difficulty; they were charming and efficient comrades, guides and general dispensers of help and information.

The congress headquarters were in the *Staderhuset* or state house and all round tables were held in the same building, the general sessions being held in the Nationalteatern or National Theater—fine buildings which suited the needs of the congress admirably.

Thirty-three Countries Represented

Each nurse was requested to register promptly at headquarters and upon registration was given a folder that contained program, arm band with letters I. C. N. and the name of her country, a congress pin, announcements, and invitations, and any other information conducive to her comfort and happiness, and all of this was done in far less time than it takes to write about it. It was fascinating to observe the arm bands and note the various countries represented—1,049 nurses from thirty-three countries! Many of them wore outdoor uniforms or some significant garb, which added to the interest and color of the gathering.

English was the language spoken throughout the meetings and the ease with which the nurses of various nationalities used our language made us realize how far they surpass us as linguists; and when one found nurses that speak three, four and five languages the thought came that perhaps the distance between Europe and the United States of America has some real disadvantages.

The first gathering of the nurses was on Monday afternoon in the beautiful church of Saint Nicholas. A special musical service was held, a new composition by the Finnish composer, Sibelius, being given in honor of the congress, and the Bishop gave an address in English. It was impressive to see this great church thronged with nurses, representing the best in the nursing profession of the world.

Special Messages from Four Continents

At the opening session on Monday night it was a thrilling sight to see the great theater filled with nurses—from Europe, from Asia, from Africa, from America and from Australia they came—each group having perhaps, some special problem in mind or some special message to bring; each having a different background but all united in their eagerness to learn what their sister nurses are doing in other lands, to exchange ideas and viewpoints, to help to raise the standard of nursing in their own land and thereby improve the health of their people. The stage was arranged with an appropriate background and on the platform were seated the officers and the speakers for each session. Many of the pioneers and leaders from our own and other countries were present and gave honor and distinction to the gathering.

Addresses of welcome were scarcely necessary for the atmosphere of Helsingfors seemed impregnated with it, yet it was delightful to hear the cordial greetings extended to us on behalf of the municipality of Helsingfors and of the medical profession and later by our president, Baroness Mannerheim. Greetings were also extended from other international women's organizations, and throughout the congress telegrams poured in from nurses and nursing organizations all over the world to remind us that they were with us in heart and spirit.

On Tuesday reports were read from the various countries. They told stories of progress, of courage, of devotion on the part of nurses, of great human need sometimes very partially met, but no one could fail to be moved by the simple yet often heroic spirit that they manifested, and by the realization of some of the enormous difficulties that nurses are facing in some countries.

Think of China, with its millions of people, one-fourth of the world's population in which one-third of the world's

*The International Congress of Nurses met at Helsingfors, Finland, July 20-25.

babies are born, a country which the world is inclined to think of as backward, scarcely touched by Occidental progress, yet they have there one hundred registered schools, nearly two thousand students, and thirteen million pages of nursing texts have been written or translated into the Chinese tongue. South Africa passed a registration act in 1899 and a law providing for an eight-hour day for nursing students in 1917. They have a four-year training, and at the present time there are two Sister Tutors in the Transvaal. A familiar note was struck at one of the round table sessions when Miss Alexander of South Africa emphasized the need of special training for the teacher of probationers, and expressed the opinion that teaching should be her exclusive work and that she should have no other responsibility. It showed us that our needs and our problems are similar, for just such a discussion might be heard at any of our state meetings.

Poland, torn as it has been by war and revolution, is getting a school organized along excellent lines, thanks to the fine work of Helen G. Bridge, director of the Warsaw School of Nursing. Their educational requirements are high and the professional course sound; but at present it is necessary for them to proceed cautiously because as a result of the war the young women are unable to stand much mental or physical strain.

Europeans Report Progress

The reports from the various European countries were read and they all told the same story—a story of the progress of nursing education under difficulties, owing to the lack of sufficient funds to supply the various needs, such as adequate housing, teaching personnel, and teaching facilities; the lack of a sufficient number of highly trained leaders and the lack of understanding and support from many physicians; also the lack of early education among the youth of the lands. Some of these needs have been rendered more acute by the World War.

It is interesting to note that the lack of funds is emphasized in other countries as it is in the United States. The question of economic support for nursing schools, in order that work of an educational character may be carried on, is an acute one.

The round table on "Subsidiary Groups in Relation to Nursing Service" was very lively. It is evident that the question of practical nurses or attendants for the care of the sick in their homes is being discussed from widely varying viewpoints, some in favor of it and some strongly opposed to it, and that is easily understood when we consider the differences in financial remuneration for nurses in various parts of the world. Undoubtedly the American nurse is far better paid than her European sister, so that the need for a less costly service is greater with us. The avenues of work are also more numerous and the demand for good nurses quite constant. An augmentation in number of those who can go into the homes to nurse is desirable and necessary. That they should be regulated by nurses is unquestioned, though all agree that it is not an easy thing to bring about. The ideal method, of course, is to have them always working under supervision of nurses. Maryland seems to be handling the matter successfully; that state has the largest number registered, more than 500, though it is smaller in size than many, and they renew their registration each year so that the nurses know who and where they are.

At the meeting on Friday night representatives of five countries were formally welcomed into the International Council. A representative from Canada welcomed France; Denmark welcomed Bulgaria; the United States welcomed Poland; Great Britain welcomed the Irish Free State and Finland welcomed Cuba. The representative of each new country was given a bunch of roses, and made a fitting response. It was a stirring evening and one that will live long in the memories of those present.

Saturday evening the farewell banquet was given, a tremendous undertaking well carried out, and a brilliant group of many hundreds of nurses gathered to break bread together before they separated—many to go to the far corners of the earth. Farewells were received from representativs of the five continents and from our president and the hour was late when we reached our hotels at the end of a happy evening.

During the week all the hospitals, General Mannerheim's Child Welfare League, and other health agencies invited the nurses to visit them, and many splendid things were seen. Delightful social affairs were planned for us—teas by the president of Finland, by the legations and by the municipality, and a boat ride to the great fortress of Sveaborg. Smaller groups were assisted in arranging for luncheons and dinners as they desired.

One of the outstanding accomplishments was the acceptance by the council of a new constitution and by-laws. It represents much previous work by the committee on revision, and hours of deliberation by the council; but it is an achievement, and will undoubtedly enable us to proceed with our affairs in a more satisfactory manner and will lead to greater development.

It was a wonderful week filled with sunshine, flowers and a great spirit of friendliness and cordiality. The nurses of Finland gave of themselves freely and without stint and the charm of it all will linger long and help us all to begin to think in truly international terms. The more we conversed and mingled with each other the more we realized the similarity of our problems and of our viewpoints. The marvelous courage with which some nurses are beating down hampering traditions and reaching towards higher and better standards in hospitals and schools of nursing, is truly inspirational. The care and patience and thoroughness with which they are working will serve as a stimulus to many and will not be the least of the benefits derived from the Helsingfors meeting.

REACTING TO THE TWELVE-HOUR DAY

The recent decision of the fourth district of the Nurses State Association of Minnesota to substitute the twelve-hour shift for private nursing in hospitals for the customary twenty-four hour shift is a step in keeping with the general trend throughout the country. The twelve hour shift, however, has decided disadvantages as well as advantages.

From the hospital standpoint the fact that the new system has proved so generally satisfactory is significant. Hospitals feel they can handle their responsibility better by not dividing their responsibility at night with a sleeping nurse and during the day with an absent nurse. It does seem as though the expense of hospital administration may increase somewhat with the necessity for more floor nurses. Whether hospitals will have fewer patients remains to be seen.

The nurses' standpoint is fully as important as any other. A working day from 7 a. m. to 7 p. m. is a long one in any vocation, and we doubt whether the change will prove a relief to the nurse. To be at work at 7 a. m. means early rising, and by 7 p. m. little energy is likely to be left for evening relaxation.—*Minnesota Medicine.*

THE PUPIL NURSE IN THE OUT-PATIENT DEPARTMENT

By The National League of Nursing Education*

THE hospital out-patient department offers unexcelled opportunities to the nurse to strengthen and enrich the service which she has to contribute to the community. It is also rich in educational opportunities for the student nurse, who, as a rule, furnishes most of the nursing service in the clinics. Therefore, the extent to which these opportunities are being utilized is of particular importance to those interested in nursing education as well as in the improvement of the out-patient department. The National League of Nursing Education, in order to determine the degree to which the educational resources of the clinics were being made available to nurses, appointed a committee to make a six months' study of the nursing situation in the out-patient department. Financial support, secured from the Committee on Dispensary Development of the United Hospital Fund of New York, enabled the league committee to engage the services of Miss Emilie G. Robson, R.N., who has been identified with the department of nursing education at Teachers' College, Columbia University, New York, and with the student work of the Henry Street Visiting Nursing Service for some years.

The aim of the study was to determine:

(a) What contribution the nurse makes to the out-patient department.

(b) What contribution the out-patient department can make to the education of the nurse.

The study was conducted in six selected out-patient departments in the cities of Boston, Cleveland, New Haven, New York and Toronto.

Each student nurse on service in the out-patient department during the period the study was being made, kept a daily record of her assignments and the amount of time spent on each. The analysis of these work sheets, the observation of these students at work, and the study of the general organization and operation of the entire out-patient service revealed a wealth of valuable material.

Because of the large number of patients who attend clinics and the ambulatory nature of their ailments, an out-patient department presents not only a greater variety of diseases but types and stages not found in hospital wards. The student nurse in the out-patient department, therefore, has abundant opportunity to increase her knowledge of disease in its various stages.

Since the nucleus of disease prevention and health promotion is to be found in clinics rather than in hospital wards, prophylactic measures for the prevention of such diseases as typhoid and small-pox are constantly practiced and programs for health promotion are here set up. There also is an opportunity to increase and broaden the experience of the student in the management of people through her multiple contacts in the clinic and to teach patients and their families and to assist in making home adjustments.

In the discussion of the findings of this report the out - patient departments studied are arranged into three groups, according to the manner in which pupil nurses were utilized and instructed in the clinic.

In the first group it was found that student nurses spent less than one-half their time assisting with clinics and more than one-third of their time in preparing for clinics and clearing them away. They received no formal instruction relative to out-patient service, and no attempt was made to enlarge or broaden this experience as a supplement to ward routine. The type of clinic assistance which they rendered required little actual nursing skill or training in most cases.

In the second group the student nurses spent more than half their time in clinic assistance and less than a quarter in preparing for clinics and clearing them away. There was a definite program of technical clinic experience planned for these students, although no formal instruction was given.

The student nursing service of the one out-patient department discussed under the third group represents the new Yale School of Nursing where an experiment in nursing education is being made. Here the student nurse spent more than half her time, 58.1 per cent to be exact, in clinic assistance, about one-fifth, or 15.5 per cent of her time, in preparing for clinics and clearing them away, and about 20 per cent in observation, instruction and conference on subject matter directly related to out-patient service.

The detailed program of this assignment and methods employed in instructing these students are contained in the full report of the study, as well as a comparison of these three groups of out-patient nursing services.

Since in the out-patient departments of the first two

Dispensary Opportunities

A NEW phase of our increasingly important out-patient service is presented in this number of THE MODERN HOSPITAL by the report of a committee of the National League of Nursing Education, which has studied the educational opportunities offered by out-patient clinics for the training of the pupil nurse and the extent to which a number of representative institutions have actually utilized these opportunities.

Nursing educators and superintendents should be informed as to how much educational material is available in the out-patient department, not only the diseases and conditions not found in the wards, but the opportunities for developing the resourcefulness of the pupil, her understanding of the social problems of patients.

While the report shows that many out-patient departments have done little to make use of these educational opportunities, an account will be found of certain institutions in which a great deal has been undertaken. The subject must be studied from the point of view of out-patient administration as a whole and not merely from the angle of nursing service.

*A summary of the study of the nurse and nursing services in the out-patient department. The committee in charge of the study was composed of Amelia Grant, chairman, Janet M. Geister, Mary B. Hulsizer, Anna C. Phillips, Isabel E. Stewart, Marguerite Wales, Mabel Welsh, Helen Wood, Helen Young, and Emilie G. Robson, field secretary. The study was conducted in cooperation with the Committee on Dispensary Development of the United Hospital Fund of New York from whom copies of the complete report may be obtained.

groups the student nurse had no correlated instruction, the knowledge of disease she acquired depended largely upon herself, her powers of observation, or the chance word of a doctor. The full report of the study contains outstanding examples of the excellent material observed in several clinics which might not only have supplemented the student's professional education but contributed towards her usefulness in the clinics and wards of the hospital.

There was in the first two groups no attempt to utilize the opportunities which would increase her knowledge of methods of disease prevention or of health promotion. She not only had no share but had no chance to observe, and knew nothing of the programs of clinics in which preventive and health measures were most emphasized.

Educational Opportunities

The utilization of the educational opportunities by the student nurse in the out-patient departments of all the hospitals studied, except New Haven, may be summarized as follows:

(a) A more or less limited practice of nursing procedures.

(b) Experience in adjusting to a more complicated environment with more varied human relationships.

There were, of course, certain values gained during this assignment, as in all her hospital experience, dependent upon the student herself, her background, type of mind, powers of observation, and chance contact with a doctor who might be interested in teaching her.

The study indicates that the scope of the nursing service in many out-patient departments is handicapped because of certain factors which may be briefly stated as follows:

(a) The lack of appreciation of the importance of the out-patient department as a whole. It has not been given the same consideration in its development as have other departments of the hospital.

(b) The out-patient department has profited less than other departments of the hospital by efforts at standardization in relation to both hospital and nursing education.

(c) The great growth of specialized departments, with special budgets in many out-patient departments. This growth tends to develop lack of unity, lack of common policy, and of understanding. These tendencies are reflected in the nursing service.

(d) The lack of an adequate proportion of permanent nursing personnel to students.

(e) The duties of the nursing personnel are not always planned so as to make the best use of the nurses' time, special preparation, and experience. Duties assigned to the nursing staff are often such as might be performed by clinic helpers, in order to conserve the time of the nurse for the broader and more important phases of her work.

(f) Where the duties of the nurse are limited to purely technical routines it is inevitable that the out-patient department service will not appeal to the better prepared nurse.

The study indicates that there are rich educational resources which should be utilized more fully in the educational preparation of the student nurse, and can be without interfering with the best interest of the patient.

The educational value of the out-patient experience to the student depends upon the following factors:

(a) The standards and development of the organization as a whole, and the content of clinic services.

(b) The close cooperation of all the departments, with a common objective in making available educational material for all students.

(c) The assignment of students to out-patient service, taking into consideration the educational scheme of the school of nursing as a whole, and the special educational background of individual students. It is evident that much student work could be better planned; experience which would be educationally profitable for the first year student is often assigned to seniors.

(d) The need for enlisting the interest and cooperation of the physician to its fullest extent in developing the nurse in the out-patient department. In both his personal relationship with the patient and in his capacity as instructor he is an important factor in the education of the student nurse.

(e) The amount and quality of teaching and supervision. This as a rule is generally inadequate. The teaching was found to be casual and unorganized. Much valuable teaching material was unused. The interpretation of certain curative and preventive conditions, community relationships, etc., all illustrating fundamental principles of sound out-patient service, were entirely neglected.

(f) The amount of time the student is required to spend in contributing service to the clinic which is non-educational for her.

In many clinics while rendering valuable assistance she may obtain a rich experience. In others, although the educational opportunities may be very great, the student can contribute very little because of the relatively short periods of assignment and the nature of the service (tuberculosis, cardiac, venereal disease clinics, etc.) demands a more permanent personnel. Furthermore, the student is less familiar with the service to be rendered to the patient, consequently she has less to contribute.

Reorganization of Nursing Services

A. It is impossible to make recommendations for the reorganization of the nursing service without considering the reorganization of the other out-patient services as well. Since the scope of the study did not make this feasible, the committee presents the following less radical suggestions, which, it believes, can do much to render the time the nurse spends in the clinics more effective both in respect to her own education and to the service she gives there:

(1) That directors of nursing services study their own out-patient departments, and keep the same close contact with them that they maintain with the hospital wards.

(2) That graduate nurses be secured for the out-patient service who are not alone satisfactory hospital executives or even satisfactory teachers, but who have as well a kind of preparation and experience that would enable them fully to appreciate and interpret the type of care the ambulatory patient requires not only in the out-patient department, but in his home.

(3) To stimulate better cooperation between the nursing service and other services in the out-patient department. Successful team work is the only basis upon which the entire service will meet the needs of the community and so furnish a desirable field for student experience.

(4) To formulate and maintain a definite program of instruction and experience for the student nurse

during the period in which she is assigned to out-patient service. To include in this assignment an opportunity for her to gain an intelligent comprehension of the clinics and services which are definitely a part of the organized community health service, and so assist her to understand the scope of these programs that as a graduate nurse she may assume her proper responsibilities in the community.

(5) Student assignment to out-patient service should have a definite relationship to the educational plan as a whole.

(a) It is recommended that early in her course the student be given an orientation in the community aspects of disease. This may include observation in out-patient clinics and homes, excursions to cooperating organizations, class work and conferences which will outline certain fundamental principles helpful in meeting the needs of their patients throughout their course. In two of the hospitals visited such a course covered a period of about fifteen hours of class work and forty-five hours of observation and excursions. Such an introduction would prepare the student to give a more adequate service to the patient in the wards and out-patient department and to gain more for herself during the period in which she rendered actual nursing service in the clinics.

B. Two plans are suggested for this out-patient service.

(1) A minimum of two or three months to be divided into short periods—two to three weeks—as a part of each main service, such as medical, surgical, pediatric and obstetrical. This should correlate with ward and theoretical work in these subjects and come at the end of the first year and extend through the second and, possibly, the third years.

(2) A block of two or more months' out-patient experience placed late in the second year or in the third, with a rotating service, selecting such clinics as would best supplement and round out the needs of the student.

Analysis of Service

C. (1) An analysis of the service rendered the patient in the out-patient department shows the extent to which his treatment is dependent upon a service other than that rendered by the physician. This service varies with the type of clinic. It may include physiotherapy, radioscopy, laboratory analysis, dietary supervision, tests and innoculations of every description; also supervision and instructions in the home and clinic, assistance with social problems, and any adjustments which may be necessary to promote the successful treatment of the patient and safeguard the welfare of his family.

The medical treatment of the patient in the home also must be supplemented by an all-round service which places emphasis upon the preventive and positive health aspects of disease.

If the period assigned to out-patient service could be utilized to give the student nurse an experience which to some extent might supplement courses now being given to nurses who prepare to work in the homes, the education of the student nurse would be broadened and enriched, and her service to the patient would be greatly strengthened.

It is important that the out-patient nursing service be cognizant of the entirety of the treatment to be rendered, and that the student nurses be given an opportunity to appreciate and participate in this program.

(2) Since one of the main objects of this study was to find a way of giving student nurses a broader conception of the community health problem the committee recommends:

(a) That an effort be made for further study and experiment over a continued period of time in out-patient departments where hospital administrators and nursing educators are sufficiently interested in this problem.

(b) That in addition to developing a program for undergraduate students, consideration should be given to providing experience for qualified nurses who are interested in preparing for out-patient supervisory work.

It is suggested that those who are responsible for public health courses should consider the opportunities available in out-patient departments and that some attempt be made to develop the clinic as a practice field.

(c) That a definite preparation for nursing supervisors in out-patient work should be built up in order to meet the need for a specially trained personnel.

WHAT STUDENT NURSES SHOULD KNOW ABOUT TUBERCULOSIS

That tuberculosis is the most disastrous of all diseases to the general hospital nurse and therefore it is paramount that tuberculosis nursing be included in the curricula of nurses' training schools so that the nurse may become cognizant of the symptoms and care of the disease, were statements made by Dr. Allen J. Krause, associate professor of medicine in Johns Hopkins University and director of the Kenneth Dows Tuberculosis Research Laboratory in Johns Hopkins Hospital, Baltimore, Md., before a special meeting of members of the Illinois League of Nursing Education held October 1, at the Chicago Nurses' Club. His subject was, "Experience in Tuberculosis Nursing."

Dr. Krause stated that nurses who do not contemplate going into tuberculosis nursing should become familiar, both for the patient's and their own sake, with the following fundamentals of caring for tuberculosis; the disposal of excreta of the patient; what the bacillus is; that it has great tenacity but is susceptible to sunlight; that contact between the patient and those in proximity should be broken; and that ordinary routine is not sufficient protection.

He brought out that only two lectures on tuberculosis nursing are usually given during the year to intermediate nurses. These encompass care of the patient and care of the nurse herself.

Following his edict that nurses should have tuberculosis training he stated that the general nurse could gain such knowledge by attending sanatoriums where the disease is treated or at city dispensaries where she would see cases in all stages.

The great decrease in the death rate of tuberculosis in the last twenty-five years is due to the increase in the number of sanatoriums and the organized combat against the disease.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

FRUITS OF VALUE IN HEALTH AND DISEASE*

By Lulu G. Graves
New York

THE fruits included in this discussion, grapes, bananas, and citrus fruits—grapefruit, lemon, lime, orange, kumquat, tangerine—differ greatly in food value and in methods of serving, but have several points in common.

First, they are almost universally used in hospitals and in greater quantities than other fruits, and are obtainable in all seasons in all parts of the country. This, of course, refers to grapes in the form of grape juice and raisins.

Second, in each of these fruits nature has provided a means of protecting the edible part of the fruit from contamination. If the sealed package in which the fruits are produced is not broken by careless handling, or by some other means, we may have a food product delivered in its natural sterile state.

Third, though they may be cooked and often are, particularly when used in combination with other food materials, they are commonly eaten raw, an advantage of convenience as well as of flavor.

Fourth, with the exception of oranges and lemons, all are comparatively recent additions to our supply of food materials, though we have been familiar with grapes for a somewhat longer period. One need not be very old to remember when bananas and grapefruit were first introduced into our dietary. Limes, kumquats and tangerines are of even more recent date. Yet they are popular and are valuable additions to our menu.

Fifth, owing to the fact that these fruits can be grown only in those sections of the country where the soil and climate are suitable for their cultivation, they must often be transported long distances, and are therefore picked while more or less green, and are ripened artificially.

Climate a Big Factor in Citrus Fruits

Since the quality and flavor are greatly influenced by the soil and climate, oranges from Southern California are sweeter than those grown farther north and grapes from one locality may have flavor characteristics differing to a noticeable degree from those grown in another locality.

Of the several varieties available, the Concord grape is of greatest interest to hospitals. It is the first to appear in the market and may be had for a longer period of time than others, though it does not keep satisfactorily after it is thoroughly ripe. It has a good flavor and appearance and is comparatively low priced. It is said to be especially good for making grape juice.

The desirability of grape juice in the hospital dietary is so well known that a discussion of it would seem unnecessary. Unfortunately, it is not used as much as it should be in view of the fact that its value and adaptability to a variety of uses is well known. The liquid diet, which is all too frequently a routine broth, milk, eggnog service, might well have fruit juice added in the majority of instances. If stimulation rather than nourishment, is required, it could be diluted sufficiently to make it merely an appetizing beverage. If a more nourishing diet is needed, it could, at least, be added to the eggnog part of the time and thereby relieve the usual monotony. Its sugar content is stated as ranging from 15 to 30 per cent and it is the most easily digested form of carbohydrate; the protein, a trifle over 1 per cent, salts of sodium, potassium, magnesium, calcium and iron present, and the high percentage of water help to make this a worthwhile addition to the diet of the sick. It combines well with other fruits, makes an excellent gelatin, ice, or sherbet, and is good in custards, puddings and ice creams.

Raisins and Grapes in the Diet

Malaga grapes are always welcomed, whether served alone or in a salad or dessert. Raisins, too, add zest to what might otherwise be an ordinary pudding, cake or pie. In addition to the nutritive value above mentioned, the sugar in grapes and raisins has laxative properties. Although the skin and seeds have laxative properties in that they furnish bulk, which may stimulate peristalsis, they should not be eaten.

The banana is one of the most nutritious of foods. Mrs. Rose[1] says: "They are high in fuel value, low in price and easy to prepare. They are often cheapest when at their best, that is, when the skin has darkened and the fruit is soft, though still firm." They rank in food value with the potato, corn and green peas. Like these foods, they are usually served with some form of fat which adds to the caloric value but does not make them more difficult of digestion, as the forms of fat used are cream, salad oil, or butter, if they are baked.

Thoroughly ripened well masticated bananas are not

*This is the third of a series of articles on the use of fruit in the diet prepared for THE MODERN HOSPITAL by Miss Graves.

1. *Feeding the Family*, by Mary Schwartz Rose.
2. *Health Through Rational Diet*, 2nd Ed., Lorand, M.D.

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a burden to the digestive tract when eaten raw, if not eaten in too large quantities, though Lorand[3] says that he has eaten as many as six or eight bananas at one time without discomfort.

An important property of the fruit is that it will ripen well after being cut from the tree. The essential change that takes place during the ripening is the changing of starch to sugars and dexterins, which are more easily assimilated.

The ash of the banana is principally made up of phosphates, sulphates, chlorid of potash, soda and lime. The salt content is similar to that of the potato, and both potato and banana are useful in preventing acidosis.

In a report made several years ago Meyers and Rose mentioned the banana as a particularly valuable food in treatment of mild cases of nephritis with nitrogen retention. Suguira and Benedict[3] found that with rats fed on bananas alone there was a lack of growth and finally death; banana and purified casein with carrot extract, or yeast, constitute a complete diet for growth maintenance and reproduction. Such a diet is not adequate for the production of the proper quality of milk by the mother, though the quantity produced is adequate. He concludes that the banana contains enough fat, carbohydrate and inorganic salts but is deficient in protein and at least one essential factor, water soluble *B*.

It is a cheap food today and is one of the few which has not increased in price to a great extent. There is little waste in the banana, as 70 per cent of the solids is edible.

Citrus fruits include a number of species that originally came from China, India and the East Indies. Their introduction into this country is so recent that details of their development are not difficult to obtain. Many of those who are now engaged in the cultivation and marketing of various members of this group of fruits have seen a phenomenal growth in the industry and have themselves helped in the propagation of new varieties.

We are not slow in appreciating their merits, and oranges, lemons and grapefruit are now an accepted part of our national dietary. The popularity of these fruits is in no small measure due to two women, Mrs. Eliza Tibbetts of Maine and Mrs. Potter Palmer of Chicago.

First Seedless Orange Trees

The first seedless orange trees were sent to Washington from the swamps of the Amazon River by the U. S. consul to Brazil. The next year Mrs. Tibbetts took three of these and planted them on her husband's ranch at Riverside, Calif. Two died, but the third shrub has developed the popular navel orange. About twenty years ago Mrs. Potter Palmer recognized that the palatable flavor and agreeable acidity of the grapefruit made it a desirable breakfast fruit, and it immediately became "the fashion." A characteristic of these fruits is the thick heavy rind or peel, which often constitutes as much as one-quarter of the weight of the fruit.

This peel contains an abundance of volatile oil which is used commercially. One of its uses is in the making of extracts, lemon extract, orange extract, and oil, or essence of bergamot, made from limes grown in southern Italy. A confection is also made from these peels, candied orange, lemon and grapefruit peel, which in addition to being a confection may be used to flavor puddings, ices cakes and drinks as well as for a garnish. The process of candying them is comparatively simple and inexpensive, thus making it possible to have a supply in the household or hospital kitchen. Such large quantities of these fruits

3. Suguira & Benedict; *Journal Biological Chemistry*, 1918.

A scene in a juice extracting factory. Note that the workers wear rubber gloves while handling the oranges.

are used in hospitals that enough peel is usually available for candying any day that one has time to do it. When the hospital budget will not permit of maraschino cherries, pistachio nuts, preserved ginger and similar high priced garnishes and flavors, these candied peels are a most desirable substitute.

Other characteristics of these fruits are the organic acids, notably citric, with lesser amounts of phosphoric and malic, which give them a distinctive but pleasing flavor; and their antiscorbutic properties due to the presence of vitamin C. With the exception of limes these fruits are also valuable as sources of vitamin B. Since so much material is now available on the subject of vitamins and because the vitamin content of citrus fruit is recognized as an important dietetic factor, the point will not be elaborated upon in this discussion. A small amount of sugar is present in these fruits, varying from 1 per cent to 10 per cent, and a large amount of pure sterile water, thus making them desirable in the diet for diabetes, obesity, liver disturbances and constipation.

Fridenwald and Ruhrah[4] advocate liberal use of citrus fruits in the diet where the nitrogen content should be low. They further recommend their use with the addition of sugar to enhance the caloric value in diseases where such is desirable. For the growing child the mineral salts, especially calcium and potassium in oranges, is worth considering.

Juices Stimulante Digestion

These juices stimulate digestive secretions and may thereby aid a sluggish digestion. When served at the beginning of a meal their refreshing and agreeable flavor is often helpful in arousing a languid appetite. While the belief, held at one time, that oranges have laxative properties has proved to be unfounded there are still many reasons for making them a regular part of the week's menu. Margaret Chaney, experimenting with children in Berkeley, Calif., in 1923, found that in a number of instances oranges were preferable to milk for a between meal lunch, as they do not detract from the consumption of food at meal time, and with many they are a source of gain in weight. For school lunches they have the ad-

4. *Diet and Disease*, Friedenwald & Ruhrah, 5th edition.

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ditional advantage of ease in handling and in serving.

Dr. Gegenbach confirms this in his statement[5] "Fruits in liberal quantities tend to overcome gastro-intestinal auto-intoxication which so frequently causes so-called stomach or bilious attacks in children. One of the most effective means of combating acidosis or acid intoxication in children is the use of fruit juices, especially orange and grape juices. . . . . Fruit juices are particularly beneficial to children with fever, since they impose no strain upon the impaired powers of digestion and the alkaline salts they contain help to combat the acid intoxication usually present. . . . . Since fruit juices are readily assimilated they may be given to children with apparently insatiable appetites who demand something between meals."

Wide Variety of Citrus Fruits

The species we know as grapefruit includes the variety which is still known as the Shaddock, named after Captain Shaddock who first brought it from China. Grapefruit was originally known as Pomelo, the present known name having been used because of the grape-like clusters in which it grows. It is largest of the Citrus family. One of the smallest is the kumquat, which was also a native of China. It is oval in shape and about the size of a plum, and bright golden in color. The pulp is acid but the rind is sweet and aromatic. Usually the entire fruit rind and all is eaten. Kumquats make excellent jam and marmalade and are very good candied, besides making an attractive fruit in a salad. There is an increasing demand for the tangerine type of fruit, which includes the mandarin and the satsuma. The mandarin is a small fruit flattened at the end and having a loose dark colored skin. It is mild in flavor but rather highly perfumed. The pulp is not juicy as in other types of citrus fruits, and can, therefore, be eaten without the aid of a spoon. For this reason it is known as "the kid glove" fruit.

The lime is of the lemon specie and grows in the same regions. It is smaller than the lemon but its skin is thin and very juicy; the juice is more acid than the lemon so that even at a higher price it may not be more expensive. Lime juice is used in medicine and is a valuable antiscorbutic. It is used a great deal by people who do not have access to fresh vegetables. It is sometimes adulterated with salicylic acid or other artificial preservatives instead of being preserved by sterilization.

The marketing of the juice of oranges, lemons and grapefruit in glass bottles is a new industry rapidly coming into prominence. If the producer uses only good fruit handled under favorable conditions, marketing these fruit juices in this form has many advantages. This, in common with any canning or dehydrating process, gives opportunity for the unscrupulous manufacturer to employ irregular methods, such as using inferior fruit disguised by an excess of benzoate of soda or similar preservative. Again, as in all industries, we have reliable firms producing a good quality of fruit juice that merits our consideration. Unfortunately, the high temperature necessary for sterilization has a tendency to give a bitter flavor to the juices, so that even a good product may have an objectionable flavor.

Another method of preservation is by freezing. Constant agitation of the juice during the freezing process prevents ice from forming and makes it possible to freeze out the particles that spoil easily. This obviates the bitter taste due to heat.

In the high grade plant careful selection of fruit and sanitary methods of bottling insure a quality of juice equal to that obtained by the most careful methods in the home.

The fruit is dropped into a caustic soda solution for five minutes in order to destroy any organism on the outside of the fruit. It is then passed over revolving brushes with stiff bristles and thoroughly scrubbed under clear streams of water. It is sliced with a revolving disc knife made of silver, to prevent tarnishing from citric acid. As the juice is extracted a further precaution is taken by having the workers wear rubber gloves, since there may be dirt or germs on the pores of the skin or around the finger nails which soap and water will not remove but which might be extracted by the citric acid.

All pipe fittings and connections in the plant are of silver and all equipment with which the juice comes in contact is of glass, silver or surgical white rubber.

The bottled juice is more concentrated than the natural juice, as about 50 per cent of the water is extracted before bottling. In some plants this is done by heat and in others where the preservation is a freezing process other methods of condensation are employed. The concentration facilitates marketing, and addition of water when serving is a simple matter. The bottled juice requires care in storing similar to that of the natural fruit.

Where oranges and lemon juice is used in large quantities a great saving can be effected by the use of an electric juice extractor now on the market. Some large institutions where a large quantity of orange juice is consumed daily have found that through the use of this device they have been able to reduce their orange purchase one-fourth.

The following recipes illustrate the use of bananas and citrus fruits in preparing appetizing desserts.

½ banana
1 tablespoon creme de menthe or
1 tablespoon maraschino
Pinch of salt
2 tablespoons minced pineapple
1 tablespoon sweet or sour cream
Lady fingers
1 teaspoon honey

Slice the banana very thin, place in a cup with the maraschino or creme de menthe, salt, and set on ice for half an hour. In a separate cup mix the pineapple and honey. When ready to serve, pour the contents of the cup into a glass and top with the cream or omit cream). Serve with lady fingers.

Syllabub

1 pint cream
whites of 2 eggs.
4 ounces grape juice
¾ cup powdered sugar.

Whip the cream and add the sugar. Beat egg whites stiff. Mix cream and egg white, add grape juice and serve as a sauce over oranges, bananas, berries or pineapple.

NEWS ITEMS

Mrs. Agnes O'Dea is spending two months in southern Europe. Miss Harriet Wells succeeds Mrs. O'Dea as administrative dietitian at the Presbyterian Hospital, New York.

Daisy Ellethorpe, formerly of the Montreal General Hospital, Montreal, Que., has accepted a position at the Pokegama Sanitarium, Pokegama, Minn.

Bertha Clow of the National Dairy Council, is doing research work and part time teaching at the University of Wisconsin, Madison, Wis.

5. F. P. Gegenbach, M.D. *Ripe Fruits and Happy Children. Sunset*, Aug., 1923.

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A MODERN DIET KITCHEN SINK

By Arthur F. Mathesius
Marine Works, New York

Almost overnight the old-fashioned sink has been revolutionized by the introduction of the new model dishwasher-sink recently placed on the market. Leading architects, hospital superintendents and dietitians everywhere have been quick to grasp its good features—efficiency and utility. It appeals to them because it saves space, and the tendency in diet kitchen construction does not permit a very great surface area for any one piece of equipment. In the dishwasher sink space is required for one piece of equipment instead of two. The capacity of this sink with dishwasher compartment gives within forty-two inches the equivalent of an ordinary sixty-inch sink. The hospital superintendent and dietitian find in this unit both a sanitary device that washes dishes thoroughly and a labor saver that is an economy and that gives satisfactory results.

In the compartment on the right is contained the mechanism of the dishwasher; racks and trays fitting into this compartment have a white enamel surface with rubber finish. The sink is connected with plumbing and electricity and occupies a space forty-two by twenty-two inches from front to back. The whole appliance is porcelain. enamel. In place of the old sink, piled high with dirty dishes, we have here a sanitary receptacle in which the dishes are placed out of sight and the neat flat cover becomes a convenient drainboard, when in place. The dishes are washed automatically with no bother. Instead of the dishes being handled with wet soapy fingers, with the attendant liability of breakage, they remain stationary and safe in the dishwasher until at the touch of a button, the swirling cleaning power of the hot water in action carries away all traces of grease and food, leaving the dishes clean and shining.

The operation of this machine is simple. The dishes are scraped as in hand dishwashing, and placed in compartments of the bottom tray, as shown in the illustration, alternating pieces of different shapes and sizes to avoid nesting. Dishes must all face in the opposite direction to that in which the dasher revolves so that water will strike faces and not backs of dishes. Dishes should lean backward in the compartment, not forward, and silverware should be placed handles down in the silver basket and spread out uniformly, and cups and glasses placed bottoms up in the top of tray. Speed in loading this tray is quickly acquired.

With the machine filled, washing powder should be sprinkled over the dishes. A washing powder should be used that has been found to combine with the water being used. The drain valve is closed and water runs into the machine through the swinging nozzle until the float valve comes flush with the bottom of the water gauge. Best results will be obtained if this water is not too hot, as egg and other albuminous substances may be cooked on the dishes. The machine is provided with an overflow so that any excess water will immediately drain out. The washing process requires about five minutes varying with the number and condition of the dishes.

The dirty water is drained off by opening the outlet valve after the water has run out and the cover is removed. Then allow a little water to run through the dishwasher before closing the drain. This will wash out any accumulation of sediment in the bottom, with this fresh supply of hot, clean water; again press the switch and let the dishwasher operate for not more than a minute to rinse the dishes. In this rinsing operation it is desirable that the water be as hot as possible. Steam connections can also be attached to this machine and operated at will for heating the water. The china dishes will dry without wiping, provided that the rinse water is hot enough, but silver and glass should be dried and polished.

The container or well is made of heavy gauge sheet copper, tinned on the inside and with a white enameled surface rubber finish, thus presenting a practically self-cleaning surface under grease action. The cast bowl of the base of the inverted cone shaped bottom is made of brass. The dasher blade itself is aluminum and the racks of brass heavy gauge wire are white enameled rubber finish. The inlet is designed to introduce water in a cone-shaped spray, that seems to soften the food and grease preliminary to the washing operation. The gear case casting also becomes the motor base, thus further insuring unnecessary duplication of parts and providing the shortest, quickest and most direct application of power to the dasher. It furthermore makes possible perfect alignment of motor and gear case at all times and is equipped with one-fourth horse power motors of standard and approved manufacture.

MEDICAL STAFF RESPONSIBILITY

The special feeding of the sick is too often considered the problem of the dietitian alone. This is a mistake, for unless there is a feeling of keen interest and responsibility on the part of the medical staff as well, no system of special diet can successfully be carried out.

To the doctor's province, of course, belongs the diagnosis and the diagnosis determines the prescription. The prescription of a diet, however, should not be an arbitrary decision of the doctor that his patient shall have so many grams of protein or so many calories per day, or a stipulated quantity of this or that kind of food. Cooperation with the dietitian should begin here, for her training in scientific food work makes her better qualified to decide as to these matters than the average doctor. Diet prescription then, must be the result of the combined thought and interest of the doctor and the dietitian.—Edna M. Prentice, San Francisco Hospital, San Francisco, Calif.

Quindara Oliver has given up her position at the Children's Hospital, Boston, to accept one with the Thompson Spa Restaurant.

Helen Glasier, who was previously at the Deaconess Hospital, Buffalo, N. Y., is at her home in Warsaw, N. Y.

Mrs. Mary DeGarmo Bryan is an instructor in the nursing department, Presbyterian Hospital, New York.

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"When I was in the hospital"

—one subject of especial interest that discharged patients always talk about!

How natural it is, that in every story of hospital experiences, there should be unfailing mention of one particular subject—the *quality of the food!*

A discharged patient will remember, of course, to comment on the equipment of your hospital, and the care accorded by physicians and nurses. But the food is always a subject of especial interest.

What an excellent chance this is to build added good will for your hospital, increased prestige! Serve not simply healthful dishes; but dishes that taste *exceptionally good,* dishes that have the extra relish that appeals to finicky appetities. You may be sure your patients will appreciate them. You may be sure they'll praise them to their friends.

In the distinctively fine flavor of every Libby Food, there is just this extra shade of goodness that flagging appetites expect. Take Libby's Mince Meat, for example. In this, more than 16 choice ingredients are skillfully combined to make the richest, most delicious flavor!

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Boston, Mass., 52 Eastern Ave.
Buffalo, N. Y., 202 Perry St.
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Denver, Colo., 1738 Wynkoop St.
Detroit, Mich., 212 New Telegraph Bldg.
El Paso, Texas, 403-5 E. Main St.
Ft. Worth, Texas, Ft. Worth Stock Yards
Hartford, Conn., 29 Huntley Place
Houston, Texas, 1213 N. Main St.
Jacksonville, Fla., Union Terminal Bldg.
Kansas City, Mo., 1522-24 St. Louis Ave.
Los Angeles, Calif., 1340 E. 6th St.
Memphis, Tenn., 693-9 S. Main St.
Minneapolis, Minn., Minnesota Transfer, care Central Wholesale Co.
Montreal, Que., Canada, 345 Craig St., West.
New Orleans, La., 418 S. Peters St.
New York, N. Y., 605 W. 27th St.
Norfolk, Va., 517 Front St.
Oklahoma City, Okla., 319 E. Grand Ave.
Philadelphia, Pa., 5th & Willow Sts.
Pittsburgh, Pa., 209 Ferry St.
Portland, Me., 253 Commercial St.
Portland, Ore., 41 Front St.
Salt Lake City, Utah, 404 Vermont Bldg.
San Francisco, Calif., 132 Pacific St.
St. Johns, Newfoundland, 190 Duckworth St.
St. Louis, Mo., 206-10 S. 7th St.
St. Paul, Minn., Minnesota Transfer, care Central Wholesale Co.
Savannah, Ga., 565 W. Hull St.
Seattle, Wash., 225-7 Jackson St.
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Salmon
Boneless Chicken
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Mince Meat

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York

FINDING WHO'S WHO*

IDENTIFICATION INDEX IN HOSPITALS AND OUT-PATIENT DEPARTMENTS

By May Ayres Burgess, Director, Statistics Bureau,
Committee on Dispensary Development, New York

WHEN J. M. Smythe is brought into the hospital as an emergency case it is natural that his faintly murmured name should be spelled "S-m-i-t-h" on the history folder. Two years later, however, when Mr. Smythe voluntarily enters the hospital to be prepared for an operation he is able to devote his whole attention to the processes of admission, and carefully gives his name as "J. Montgomery Smythe, S-m-y-t-h-e" Before making out his card the clerk looks under the SMY's, and finds no J. Montgomery. She therefore counts him as a new patient, a new medical history is started, and the story of the earlier attack, which might have provided much illuminating information to the surgeon now in charge, lies forgotten, in the same filing drawer, ten inches away.

In the out-patient department, the problem of identifying patients is even more difficult than in the in-patient department. The patient who is sick in bed may be left to lie there for hours or days, if necessary, while the clerk hunts for his earlier history. Moreover, if as many as twenty-five or thirty bed patients are admitted during the twenty-four hours, the hospital feels that it has had a day, but in an out-patient department one hundred, or five hundred may be admitted in a single afternoon; and there the process of discovering whether or not a patient has attended the clinic service before, and if so of locating the whereabouts of his medical history, becomes a matter to be handled not in days or hours or even minutes, but in seconds. The whole line of waiting hundreds must be held up while the identifying of one patient is in progress.

Originally Filed Alphabetically in Many Clinics

In the early days of hospitals and dispensaries, medical histories were originally filed alphabetically. All the Smiths are filed under SMI, and all the Smythes under SMY, and in cases of doubt the admission clerk looked under both headings until she found the history she needed. As the service grew, however, it was soon discovered that this alphabetical filing required altogether too much time. There are other names than Smith. Kelly is spelled in fourteen ways, Baker in seventeen, Cohan in twenty-eight, and Snyder in at least thirty. When Frank Snyder stands at the admission desk, it is unreasonable to expect the admission clerk to go to the history file, turn to the Schneider's, pull out all the histories of all the Frank's, open each one, read the identifying data on each of the face sheets, discover the histories are all for the wrong Frank, close the folders, return them to their places, turn to the Schneider's, pull out all the histories of all the Frank's open each one, . . . and so on through thirty different groups of Snyder's.

The obvious solution of the difficulty was to give each patient a history number on his first visit to the department. All his medical sheets were headed with the same number, and placed in a folder, filed numerically. The patient was given an admission card that showed the number assigned to him. Then, when he approached the admission desk, all he had to do was to show his ticket, in order that his own medical history could, without fail, be located and sent to the ward or clinic with him.

Numerical File Generally Used in Large Hospitals

In practically all of the large hospitals that have out-patient departments the numerical file has taken the place of the earlier alphabetical file for medical histories. The change has greatly speeded up the work of locating histories, and has decreased the number of mistakes where a medical history belonging to one patient was used by the doctor for recording the treatment given to another patient by the same name. There is still difficulty, however, in all cases where the patient either loses, forgets, or secretes his admission ticket. Not every patient brings his ticket every time. Often a year or more has elapsed between visits, and the little card is easily mislaid over such a period. Often too, the patient has an idea that if he poses as a new patient he may get a more thorough examination, or a change in doctors, or be allowed to see the doctor earlier. He may claim never to have been to the hospital before, even though he has a full medical history somewhere in the files. It is, therefore, usually wise to look up every patient who does not actually bring an admission ticket with him; and that means that there must be some sort of identification index where the patient's medical history number, if he has one, can readily be found without the labor of pulling large numbers of folders from the files and reading the contents of each one.

If two or three patients have the same name, the easiest

*The article is based on a careful study of identification indexes in different parts of the country.

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way of telling them apart is by noting their ages, and the names of their near relatives. The address, which is frequently relied upon, is apt to be unsatisfactory; largely because addresses change so frequently that the patients themselves forget what they were. It is often hard to remember where we lived five years ago; but it is easy to remember our wife's first name; and the names of our sons and our daughters, our brothers, or our sisters. Moreover, we can make quite a good guess as to how old we were then and how old we are now, even though some may lop off a few years in the process.

The identification index usually provides a card for each patient, showing his name, age, sex, the names of his near relatives, and the number under which his medical history can be found in the main history file. Sometimes, also, the identification card gives the street addresses where he has lived, and the different hospital departments in which he has been registered. These are helpful additional bits of information, but since they are less easily kept up to date, and more likely to be forgotten by the patient, they are not so important as the sex, age, and relatives entries for identification purposes.

Cards Filed by Sir Name

Since the patient is surer of his own name than of anything else, the easiest identification file to work is that in which the cards are filed alphabetically by name. In the straight alphabetical file, however, the Smiths and the Smythes are in separate spots; the fourteen Kellys in fourteen different places; the Cohan's widely distributed among the C's, the G's and the K's; and the Snyder's in perhaps all of their thirty different locations. It is necessary, therefore, if the danger of losing histories is to be avoided, to use some adaptation of the straight alphabetical file, which will automatically throw together those names that are pronounced alike, but spelled in so many different ways. This can be done by setting up arbitrary rules; such as "Spell anything which sounds like Snyder S-n-y-d-e-r, no matter how the patient spells it," "Don't enter J. Montgomery Smythe as J. Montgomery Smythe, enter him as James M. Smith," etc., etc. Such rules are difficult to formulate wisely; and they are rarely strictly followed. It is much easier to adopt one of the standard identification methods, where the grouping of names depends, not upon a set of special rules of occasional application and doubtful logic, but upon a carefully worked out method for throwing together all names, not according to the way they are spelled, but according to the way they are pronounced.

One such method takes into account both the first and the last names of the patient, and files according to the combination they make. By taking only the first two or three letters of each name much of the confusion due to different spellings is avoided. Smith and Smythe, for example, both begin with the letters SM; and in one of the duplex systems the two names would be filed together, with all the Albert Smiths and the Alexander Smythes in a group behind the SM-A guide.

The duplex systems, of which there are several, are simple to understand and easy to control. They are generally satisfactory so long as care is taken that the groups of cards between guides shall not become too large. It is rarely wise to permit more than twenty-five index cards in a single group, no matter what sort of index is being considered; but in an identification file, where speed in handling is essential, the larger group may become seriously inefficient. It is necessary, then, to insist that the particular system being installed shall make provision for splitting up the groups as they grow. This can be done by providing special name cards. Instead of filing the Alberts and Alexanders together under the SM-A guide, they could be separated and filed under the SM-Alb and SM-Ale respectively; or in case of the John Smiths of whom there will usually be a goodly number, the special guides may run SM-John, SM-John A, SM-John B, etc. Again, if the SM-John A. cards become too numerous, additional guides can be provided with the middle names written out in full. Or, if necessary, groups with exactly the same name may be subdivided according to age. It is a simple matter to provide sufficiently detailed guides so that there will never be more than twenty or twenty-five cards between guides; and if this rule is followed one of the duplex systems can usually be relied upon to give good service. For some of the Cohans and the Snyders it will be necessary to look in three or perhaps four places where the duplex system is used, but that is better, surely, than being obliged to look in twenty-eight or thirty.

A new index system has been invented that is being satisfactorily used in large out-patient departments. Under this system cards are filed according to surnames. These surnames, however, are filed not according to the ways they are spelled, but according to their most distinctive sounds. The distinctive sounds in Snyder for example, are SNDR, and so also are the distinctive sounds of Schneider or Sniter or Schenyder. Since their distinctive sounds are identical, all the forms of Snyder, Schneider, Sniter . . . etc., would automatically fall into one group. They would stand behind the SNYD guide, and be subdivided only according to the first names of the patients.

System Based on Phonetic Method

This index looks complicated, but in practice it is so simple that the ordinary clerical worker has no difficulty in using it, and new workers can become familiar with it easily in the course of a morning. It comes nearer than any other of the standard systems to providing one place, and one place only, for all names that sound alike, no matter how they are spelled. Even errors due to careless writing are largely eliminated, because of the interesting phonetic method upon which the system is based. The simplicity of the method makes for great speed not only in filing but in finding cards; and this, combined with its remarkable accuracy, makes it particularly valuable for the large out-patient department identification file. It can be seen in active operation at the out-patient department of the Lakeside Hospital in Cleveland.

There are a few leading firms who specialize in filing supplies. It can usually be arranged for one of these firms not only to sell the cards, guides, and filing cases, but to advise as to quality, and filing method, and sometimes even to supervise the actual typing of the cards, the placing of them in correct order behind the appropriate guides, the training of the clerical force in their use, and the making of a special set of office instructions to meet the problems peculiar to the needs of that specific out-patient department. If such service can be procured, the original cost of installing the file will, of course, be larger than if it is handled under the direction of the superintendent or of the head of the history room. The original cost, however, is rapidly met by the increased usefulness of the file, and the decrease in the number of clerks required to handle it. A good file, installed correctly, and using the best available equipment, may cut down the clerical force in half. Mistakes made either by selecting equipment of an inconvenient type or inferior quality, or by placing cards incorrectly in the trays, may result

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in a permanently crippled index, and therefore a permanently inflated payroll. It pays to do the job rightly in the first place.

The amount that must be invested to install a thoroughly modern identification file depends, of course, upon the number of patients who will have to be identified, the condition of the present identifying information, and the degree of efficiency which is essential. If there are, say, 50,000 patients to be cared for, the costs might run as follows:

50,000 rotary cut, light weight, best quality, 3x5 cards about	$120
2,000 celluloid tipped guides, 3x5, about	80
Card cabinet, holding 50,000 3x5 cards. Counter height, roller bearing drawers, best construction about	130
Total cost of equipment about	$330
Supervision and clerical service for installation about	$500

The cost of supervision and clerical service might, of course, be much less or much more than $500, according to the difficulty of the task, and the intelligence and training of the regular staff which is to handle the records. It pays not only to buy the best available materials, and to use the most effective filing methods, but to place the actual work of installation in competent hands. For the identification file is in the nature of a permanent investment. It will be used vigorously, all the time the clinics are in session, and it will be expected to last forever. It merits thought.

Visible or Vertical Index Method

In planning the index, choice must be made between the "visible" and the "vertical" methods. It is worth remembering in this connection that the reason why most people are enthusiastic about the visible index is that they have never seen a modern vertical index. What they have in their offices and naïvely think of as a vertical index is often a relic of the early days when the vertical method was first being advocated, twenty or twenty-five years ago, as an improvement upon the earlier horizontal method, where sheets were laid flat, one above the other, in drawer or book. These relics consist of thousands of old, machine cut, poor quality cards and a scattering of dirty dog-eared guides, carelessly jammed into wooden boxes piled high in disorderly array on desks, tables, shelves and on the tops of other filing cases. No wonder the executive is disgusted with them. He ought to be. But he is just a bit stupid if he takes it for granted that the ancient thing he calls his file is like the best vertical files of today.

There are several on the market, and each has some advantages over the others. Practically all of the visible files are extremely expensive. Cabinets capable of holding as many as 50,000 cards will cost from $1,000 to $6,000 depending upon the type selected. A single vertical card cabinet, of the best type, holding 50,000 cards or more, can be secured for about $130. Again, the visible files take up large amounts of floor and wall space. In one of the popular systems the cabinets necessary for 50,000 cards stretch for some twenty feet along the wall, as high as the clerk can comfortably reach. If one clerk were attempting to handle the file she would have to be on her feet all the time; and most of the period would be spent away from her desk. It would usually be necessary, therefore, to have one clerk attending to admission of the patients, and one or two others doing nothing but hunting for the cards.

With the vertical filing cabinet, on the other hand, every one of the 50,000 or 60,000 cards can be reached by the clerk as she sits at her desk. No card is more than seventeen inches away. She never has to get up. That means that in many out-patient departments a single clerk can handle both the admitting of patients and the looking up of identification cards. Moreover, in the visible file just cited the 50,000 cards are fastened in place on trays or shelves which must be pulled out and pushed in whenever the cards in them are needed. There are 708 of these shelves, as compared with the six drawers of the vertical cabinet.

It is the writer's opinion that it is actually easier to find the cards, if there are more than 2,000 of them, in a good vertical file than in any one of the so-called visible files. It is certainly less expensive in terms of money, floor space and clerk hire.

HOLYOKE'S NEW DISPENSARY

The Holyoke City Hospital, Holyoke, Mass., recently recognized the need for dispensary service in that city by opening an out-patient department. Medical, surgical, pediatric and venereal disease clinics are held twice a week and orthopedics bi-weekly. All the clinics are run on the appointment system except that for venereal disease.

The staff is composed of a chief of each service, who has under him two assistants. Chiefs of service were chosen from the group of senior physicians on the house staff of the hospital.

The out-patient committee showed considerable ingenuity in utilizing an old portable building on the hospital grounds by partitioning it so as to give adequate arrangements. Sheet rock and composition board were used for partitioning. The dispensary contains five small examining rooms, a waiting room, an admitting office and a room for taking histories.

COLORED SIGNALS LOCATE DOCTORS

To enable the information desk of a large out-patient department to tell easily in which clinics physicians are working, one enterprising doctor has made up a chart with the names of the physicians printed down the left-hand side and a column for each day of the week. Opposite the physician's name, in the appropriate column, a colored label is pasted. Different colors indicate different clinics. For example, pink stands for pediatrics. Thus, if Doctor J. attends the pediatric clinic on Monday, Wednesday and Friday, a pink label will be pasted opposite his name in the Monday, Wednesday and Friday columns of the chart.

A MIRROR THAT REFLECTS DISTANCE

How to do effective work in crowded quarters is a constantly recurring problem in dispensaries. Some eye clinics, lacking the twenty feet necessary when the patient's distance sight is to be tested, have the chart printed backwards and place it opposite a mirror. The patient then faces the mirror and reads the chart reflected in it at the correct distance.

THEY TELEPHONE FOR CLINIC RECORDS

On clinic has speeded up the time it takes to get records to the clinic room by having an internal telephone system. Every clinic room is connected with the record room so that those in charge can telephone direct for whatever they need.

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OCCUPATIONAL THERAPY AND REHABILITATION

EDUCATIONAL OPPORTUNITIES AT OREGON STATE TUBERCULOSIS HOSPITAL

By Hubbard G. Adams, President, Sanatorium Study Club,
State Tuberculosis Hospital, Salem, Ore.

THE present effort for the education of the convalescent adults at the State Tuberculosis Sanatorium, Salem, is the realization of the dream of many years, on the part of our superintendent, Dr. G. C. Bellinger, and is along the lines of development recognized as of value, both from the viewpoint of occupational therapy, and vocational study. Some years ago, correspondence courses of study were offered through the extension service of the University of Oregon, the expenses except for texts and supplies, to be carried by the university. The response was slight, partly because of the fact that no one was available to push the work and keep up interest. Last fall, however, Mrs. Lura Cass French was engaged to take charge of the educational work at the sanatorium, and after she had perfected the organization of the eight elementary grades, she offered her services as supervisor of such work as would be offered through university extension.

Study Club Organized

Accordingly a temporary organization was formed of which Mr. Cox, one of the patients, was chosen as chairman. A petition was drawn up, circulated, and delivered to the proper authorities. The text of the petition was as follows:

"Whereas, there is great interest on the part of the patients of the Oregon State Tuberculosis Hospital in securing either correspondence, or similar courses under the supervision and direction of Mrs. French, we present this petition for your consideration;

"Whereas, such study provides a means of keeping our minds from becoming dormant and of keeping alive our interest and enthusiasm, thus preventing to a certain degree an undue amount of worry concerning our physical condition;

"Whereas, it is understood that such study is entirely optional and will not hinder in any way the prescribed treatment and rest necessary for our recovery, and;

"Whereas, by taking such study we would not only widen our present interests, but also fit ourselves for some future vocations thus making profitable for us this enforced idle period in our lives;

"Therefore, we, the undersigned patients of the Oregon State Tuberculosis Hospital, do respectfully petition the superintendent, the resident doctor, and the matron, for the privilege of taking such courses, and at the same time do petition them for all possible help in making this movement a success."

Following this petition, Miss Mozelle Hair of the university extension division, on invitation of the superintendent, addressed a meeting of all interested and gave considerable information on the various courses being considered, and advised the prospective students. The thirty-seven signers of the petition thereupon formed a permanent organization, elected officers and an executive committee, drew up suitable by-laws, and chose the name "The San Study Club," under which name it has now functioned for over six months.

Special Emphasis on English

In the work being done, especial emphasis is placed upon the study of English. Seventeen were enrolled in an entrance English class. This is the largest number enrolled in any one subject, and it was arranged for this group to meet every Thursday evening with Mrs. French as instructor. A class in typewriting was also started and hours were assigned for practice on the typewriter which Dr. Bellinger secured. Beside the entrance English, university courses in algebra, geology, botany, and commercial English were taken. From other than university sources, several members of the club took electrical engineering, while with the help of Mrs. French others took arithmetic and elementary English. German and French is likewise being studied. The group taking this work is under the instruction of one of the patients, Mrs. Kahlies. Reading courses on machine shop work, home making, and landscape gardening, are also part of the work handled by various members. Interest in the work has continued at a high level, the only slackening of effort occurring, being due to illness or departure from the sanatorium.

In the club organization, the executive committee is a standing committee and consists of the officers and one club member. The president is chairman, and calls meetings whenever it is necessary. The library committees, appointed by the president, consist of groups of two members, each group in charge of a pavilion library and the hospital library, thus making four groups under the head

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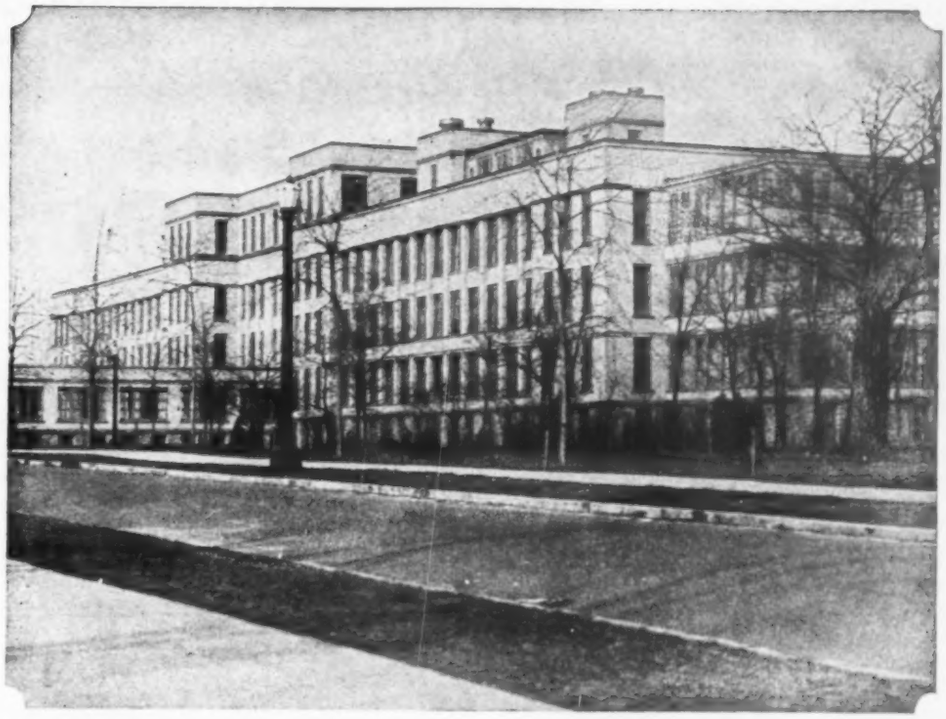
BUFFALO CITY HOSPITAL
BUFFALO, NEW YORK

Franklin J. and Wm. A. Kidd
Architects



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Queens Hospital, Honolulu
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Paterson Gen. Hospital, Paterson, N. J.
Niagara Falls Memorial Hospital, Niagara Falls, N. Y.
Maternity Hospital, Cleveland, Ohio
Kern County Hospital, Bakersfield, Cal.
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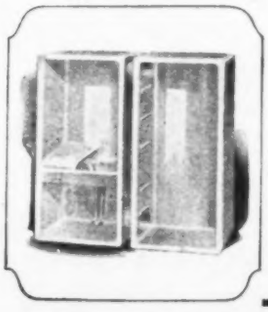

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librarian. The task of organizing the library is only in its infancy but much is hoped for along this line, and the work will be carried on to a successful conclusion.

Special committees are appointed from time to time, an example of which is the one that had charge of the entertainment reported in the May issue of *Health First.* Another committee of that nature is planning an exhibit of club work to be given in the schoolroom in the near future, when it will be open to the public.

It is hoped that there may be developed an outside interest in the work, and that helpful cooperation may be realized in the home communities to which these students return, thus making a place for them of greatest use in the localities in which they live.

During the summer vacation, and Mrs. French's absence, the work will continue through group leadership that has been developed during the regular school year. —Reprinted from *Health First.*

MANY HOSPITALS REPRESENTED AT CALIFORNIA STATE MEETING

PROGRESS reports and a large exhibition of work from various hospitals of the state were the interesting features of the second annual meeting of the California State Association of Occupational Therapy held at the St. Francis Hotel, San Francisco, Saturday, September 5, 1925. At the business meeting Saturday morning Louise Cadwalader, Berkeley, secretary-treasurer of the association, read a short paper setting forth the aims of the association and describing the monthly meetings that have been held in San Francisco since March. Letters of greeting were then read from T. B. Kidner and Mrs. Eleanor Clarke Slagle, president and secretary, of the American Occupational Therapy Association.

The by-laws drawn up by the special committee chosen by the national association were read, discussed, and adopted.

A round table was then held and reports were given from various hospitals of the state. Eunice Cates, chief aid, U. S. Veterans' Hospital, Livermore, chairman of the round table, gave a short report of the work at the new hospital at Livermore. Sarah Kennedy, representing the National Soldiers' Home, Sawtelle, said that as chief of the department she was trying to emphasize the physical benefit of the work and to discourage patients working with a view toward the monetary return from the products made. Her hospital cooperates with the California Hut, the veterans' work shop in Los Angeles. Barbara Balfour, chief aid, Arroya Sanatorium, Livermore, stressed the progressive work of her department and reported that all work is done strictly under the supervision of the medical director. As Miss Balfour had just returned from a three months' visit in Toronto, Ont., she described the work that is being done in the curative workshop there.

Catherine Ledge, State Rehabilitation Commission, Marie Glindering, supervising nurse, Hahneman Hospital, San Francisco, and Elsie Georts, recently appointed chief aid, Stockton State Hospital, gave short reports of their respective work.

The following officers were then elected for the ensuing year: President, Helen Seeley, 1160 Amador street, Berkeley; first vice president, Mrs. Frances R. Vance, 601 El Centro avenue S. Pasadena; second vice president, Sarah Haseltine, 2000, Vallejo Street, San Francisco; and secretary-treasurer, Sarah Kennedy, Soldiers' Home, Sawtelle. The board members are Olivia Lee Tiedebohl, Los Angeles; Louise Cadawalader, Berkeley; Mildren Holden, San Francisco; Eunice Cates, U. S. Veterans' Hospital, Livermore, and Dorothy V. Tyson, Pasadena.

The aims and ambitions of the association were outlined by Miss Seeley in her presidential address at the general meeting Saturday afternoon. Following this address, Dr. J. Rollin French of the French and Early Hospital, Los Angeles, spoke on the subject of "Occupational Therapy for the Industrially Injured." The other address of the meeting was given by A. C. Jenson, superintendent, Alameda County Hospital, San Leandro, on "Occupational Therapy for Aged and Chronic Cases." Both speakers gave interesting accounts of the occupational therapy work in their hospitals.

After the addresses Miss Cadwalader read condensed reports from the occupational therapy departments of the following hospitals: U. S. Veterans' Hospital, Palo Alto; Livermore Sanatorium, Livermore; Arequipa Sanatorium, Manor, Marin County; Arroya Sanatorium, Livermore, and the Stockton State Hospital, Stockton.

The following hospitals had exhibits at the meeting: U. S. Marine Hospital, San Francisco; Lane Stanford Hospital, San Francisco; National Soldiers' Home, Sawtelle; U. S. Veterans' Hospital, Palo Alto; Letterman General Hospital, San Francisco; Arequipa Sanatorium, Manor, Marin County; Arroya Sanatorium, Livermore, and the Relief Home, San Francisco.

A SOUTH DAKOTA SHOP

A description of the occupational therapy shop at the Battle Mountain Sanitarium, Hot Springs, South Dakota, was recently published in the *Sioux Falls Argus Ledger.*

The sanitarium was established twenty years ago, but now the veterans of three wars are members of one great brotherhood of rehabilitation. On the ground floor of the building is the occupational therapy shop where these veterans work side by side making hammocks, rugs, baskets, lamps, and numerous pieces of furniture and leather articles. On one of the looms that take up one side of the room are rugs; tables and baskets and trays of grass and reed are lined against the other walls.

The article comments upon the development of occupational therapy and its purpose, as follows: "Just before the World War, Mrs. Eleanor Clarke Slagle instituted a movement for the introduction in hospitals and sanitoriums of a department of handcraft which was designed to occupy the patients' hands, to furnish special exercise for certain parts of the body in cases where this was needed, and to keep the minds of patients healthfully occupied . . .

"The name occupational therapy has been developed for this work, because it exactly sets forth the purpose of the work. It furnishes occupation that aims to restore health to the patients; it does not purport to teach them a vocation or to make the work remunerative. It is a blue print for the rebuilding of lives."

EXTENSIVE WORK OFFERED AT RUTLAND

A note in an issue of the *Massachusetts Health Journal* of recent date indicates that the Central New England Sanatorium, Rutland, Mass., which was one of the earliest institutions to offer opportunities for vocational training for the tuberculous, is constantly expanding its work. It now covers the following lines: Poultry raising, orcharding, multigraphing, occupational therapy, woodworking, library work, automobile work, bacteriological work and stenography.

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MEETINGS, CONVENTIONS AND CONFERENCES

TUBERCULOSIS PROBLEMS THOROUGHLY ANALYZED AT MISSISSIPPI VALLEY CONFERENCE

A LARGE representation of tuberculosis authorities and workers in the Middle West participated in the annual meeting of the Mississippi Tuberculosis Association held at Lansing, Mich., September 29 to October 1. The next meeting of the association will be held in Chicago, in June 1926, instead of in the fall, as has been the custom, in order to promote a large attendance at the National Tuberculosis Association meeting and the International Congress on Tuberculosis to be held in the fall.

The new officers elected at the meeting are Theodore Werle, Lansing, Mich., president; Dr. P. M. Hall, Ah Gwah-Ching, Minn., vice president; and Mrs. T. B. Sachs, Chicago, secretary-treasurer.

The program of the conference covered practically every angle of the tuberculosis problem and was so arranged that it appealed to public health workers, social workers, nurses, medical and hospital men and to the general public.

Child Health Education

The first day's program centered around child health education and tuberculosis. At noon a child health luncheon was held featuring a symposium of brief addresses on "Keeping the Teachers Interested." These talks brought out strongly the duty of the teacher in guarding the health of young children in the community and the best ways of keeping teachers abreast of the work that is being accomplished in protecting school children in the various states and sections of the country.

The afternoon program featured a symposium of childhood tuberculosis. "Tuberculosis Case Findings in Under-Weight Children," was the subject assigned to Dr. W. P. Brown, Cattaraugus County, N. Y., who analyzed the developments of many cases in children below normal in weight. This was followed by a demonstration on "Vitamins in Health and Disease," by Dr. H. F. Mitchell, director, nutrition laboratory, Battle Creek Sanitarium, Battle Creek, Mich., which brought out strikingly the relationship of undernourishment to the incidence of tuberculosis and the importance of proper nutrition both as a preventive measure and as a vital factor in the care and cure of the disease. The third topic of the symposium was "Health of Working Boys and Girls," presented by Prof. R. L. Cooley, Milwaukee Continuation Schools, Milwaukee, Wis., who discussed the problem of the boys and girls who are wage earners as well as school children.

The president's address was on the subject of "A Quarter Century of Reactionary Musings."

The banquet session was held Tuesday evening at the Lansing Country Club. A special feature of the session was the representation of founders of the various state tuberculosis associations of the conference. The founders were introduced individually by Dr. John Sundwall, professor of hygiene and public health, University of Michigan, Ann Arbor.

"Changing Views in Regard to the Mode of Infection in Tuberculosis," was the subject of a talk by Dr. A. S. Warthin, professor of pathology, University of Michigan, Ann Arbor. The subject of "County Nurses, Today and Yesterday," was handled by Harriet Fulmer, superintendent of nurses, Cook County Hospital, Chicago.

Pioneer tuberculosis work in the state of Illinois was discussed by Dr. J. W. Pettit, Ottawa Tuberculosis Sanitarium, Ottawa, Ill., in his paper on "Our Early Days."

The two addresses of the banquet session were on "Tuberculosis Problems of the Southwest," by C. C. Browning, Los Angeles, and "The Future of the National Tuberculosis Association," by Dr. Lindsey R. Williams, New York.

Of special interest to nurses was the clinic workers' luncheon held Wednesday noon in charge of Harriet Fulmer, R.N., Chicago. "Training Nurses for Tuberculosis Service," was the subject of an address by Dr. Robinson Bosworth. superintendent, Rockford Municipal Sanatorium, Rockford, Ill. "The County Public Health Nurse and Her Tuberculosis Cases," was discussed by Mary M. Muckley, R.N., St. Paul, Minn.

The hospitalization phase of the problem was taken up at the Wednesday afternoon program under the chairmanship of Dr. G. L. Bellis, Muirdale Sanatorium, Wauwatosa, Wis. The program featured two symposiums, one on the subject of After the Sanatorium, What, and the other on Preventoriums.

After Care Responsibility

"Our After Care Responsibility," was discussed by Dr. H. S. Hatch, Sunnyside Sanatorium. Indianapolis, Ind., who pointed out clearly the duty of the sanatorium in following up cases after discharge in order to lessen the number of relapses that confronts every sanitarium. This was followed by "Methods of Post-Sanitarium Supervision," by Dr. H. A. Pattison, Potts Memorial Hospital, New York, who outlined the procedure of following up discharged patients. The symposium closed with a discussion of his personal experiences with an aftercare colony, by Dr. Nathan Levitt, Detroit, Mich.

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Planning the Physiotherapy Department

THAT a PHYSIOTHERAPY DEPARTMENT is a part of the well-equipped hospital of today is recognized by the up-to-date hospital workers.

The scope of the PHYSIOTHERAPY department should be the first consideration, and this should be determined in conference with the medical staff, heads of the other departments of the hospital, and in relation to the community interests which of necessity gauge the demands which will be placed upon it. The constantly increasing growth of this service should also be considered so that provision may be made for future expansion and adequate facilities. Always this department must be considered in its proper relation to all other services of the hospital so that it may function efficiently.

The location of the PHYSIOTHERAPY department is the next consideration. Obviously it should be convenient to both resident and out-patient services. A place of quiet is very desirable, and it is of distinct advantage if a southern, or southeasterly exposure can be allotted to it as the treatments have a relaxing effect on the patients. Portable equipment for bedside use must also be considered. Consultation with the architect and builder is indicated so that provision may be made for the electrical and plumbing fixtures.

The supervision and control of the PHYSIOTHERAPY department should be concentrated in the hands of a competent medical authority with a staff of trained technicians, the number of these being of course dependent upon the size of the institution, the amount of work done and the needs of the staff physicians.

Hospital workers interested in developing an efficient, well organized and practically planned PHYSIOTHERAPY DEPARTMENT can receive valuable assistance on this as well as on sources of supply for trained technicians by applying to

As a part of the program of the Mississippi Valley Conference the Mississippi Valley Sanatorium Association held its annual meeting, Thursday, October 1. The program was devoted to a symposium on "The Fundamentals in the Treatment of Tuberculosis," and to two papers.

Rest as a fundamental in treatment was discussed by Dr. L. W. Dudley, superintendent, Wisconsin State Tuberculosis Sanatorium, Wauwatosa. The importance of proper nourishment was discussed by Dr. R. L. Laney, superintendent, Lake Julia Sanatorium, Puposky, Minn., and the third element, fresh air, was discussed by Dr. Robinson Bosworth. Correlation of activities was discussed by Dr. Walter Marcley, Minneapolis, Minn.

An illustrated lecture on "Light Treatment of Tuberculosis," was given by Dr. E. B. Pierce, Howell, Mich. The other paper of the session was on, "Tuberculin in Early Diagnosis of Tuberculosis," by Dr. Everett K. Geer, Pikegama Sanatorium.

MODERN DEVELOPMENTS CHARACTERIZE ELECTROTHERAPISTS' MEETING

Progress in the development of electrotherapeutics was evident both in the papers and discussions and in the exhibition of equipment at the thirty-fifth annual meeting of the American Electrotherapeutic Association held at the Drake Hotel, Chicago, September 15, 16, 17 and 18.

One of the interesting papers of the meeting from the institutional viewpoint was "the Relation of the Physiotherapy Clinic to the Hospital," by Dr. A. Bern Hirsh, and Dr. Richard Kovacs, New York. The authors pointed out clearly that the physiotherapy clinic is an essential to the modern hospital, since this branch of treatment is rapidly becoming in demand in a wide range of medical as well as surgical cases. The importance of having the clinic well planned as regards the arrangement of apparatus and well staffed were stressed. The paper also dwelt upon the possibilities of the physiotherapy clinic to the teaching hospital.

Several of the committee reports were of interest to the hospitals aside from their purely clinical aspects. The report of the committee on radiography, radiotherapy and apparatus pointed out the dangers of x-ray treatment, stating that damage from overdose was due to the lack of knowledge on the part of physicians giving treatments. For this reason, the report stated, it is necessary that the spark gap, the milliamperage, the filter and the time of exposure should be stated in all reports as a means of protection.

The second part of the report dealt with the increase in the use of x-ray and radium in malignancy, especially in skin affections in many thyroid diseases, and in the treatment of diseased tonsils. Recent observations pointed out that radiation in many tested cases proved more satisfactory when given in divided doses rather than in large doses, since all cells are not in a state of activity at the same time.

The report of the committee on standardization of physical therapeutic apparatus explained the new multiple generator of low tension electrical current that is being found practical by many practitioners. The apparatus has been tested by the U. S. Bureau of Standards.

The report of the committee on therapeutic exercise stressed the value of such exercise in the treatment of the mentally defective as shown in several institutions.

The place of physiotherapy in the treatment of postoperative cases was described by Dr. James T. Case, Battle Creek Sanitarium, Battle Creek, Mich., in his paper, "The Value of Physiotherapy in Post-Operative Management of Surgical Cases." Dr. Case enumerated the various physiotherapeutic measures that should be included in the routine procedure of surgical cases, pointing out that much more could be done in making the patient comfortable after an operation, if nurses received proper training in the rudiments of the various phases of physiotherapy.

The American Medical Association was represented at the meeting by Dr. Morris Fishbein, editor, *Journal of the American Medical Association*, who spoke on "Facts Versus Fancies in Physical Therapeutics." Dr. Fishbein gave a brief resumé of the history of physical therapeutics, pointing out the developments that have withstood the test of time and have become recognized as agencies of cure along with the other branches of medicine in contrast to the elaborate mechanistic developments that come to light, from time to time, but are soon relegated to the mounting pile of fads and fancies. He warned the medical men interested in this branch of medicine to keep in mind that this science is but one of the branches of medicine and cannot replace other branches. If it is to succeed, he said, physical therapeutics must keep its place and not try to encroach upon the other fields of medicine.

Tribute was paid to the late Dr. Albert J. Ochsner and an unfinished paper of his on the value of physical therapeutics in surgery was read at one of the meetings.

The paper showed the definite use of such measures as massage and gymnastics in the care of postoperative cases. The point was made that too little attention is given by surgeons to the simple forms of physiotherapy that should supplement surgical treatment.

MASSACHUSETTS NURSES HOLD AUTUMN MEETING

The autumn meeting of the Massachusetts State Nurses' Association was held at the Maplewood Hotel, Pittsfield, Mass., October 9-10. The meetings on October 10 were divided into three sections, devoted to the private duty nurse, the public health nurse and the Massachusetts League of Nursing Education. The opening meeting was in the nature of a general session with a program of addresses of welcome and music.

The private duty nurses' section was taken up with two addresses, one, "The Care of Cardiac Cases in the Home," by Dr. Brace W. Paddock, Pittsfield, and the other, "Personal Experiences While Nursing in Syria," by Agnes Evon, Pittsfield.

Rural nursing problems was the subject of special interest at the public health nurses' section at which Laura A. Draper, Boston, presided. The main paper of the session was read by I. Malinde Havey, assistant to the national director, Public Health Nursing Service, New York.

"Why Postgraduate Study?" was the subject of the paper presented at the session of the league of nursing education, under the chairmanship of Carrie M. Hall, president, National League of Nursing Education, Boston. This section was under the chairmanship of Sally Johnson, Boston.

One of the interesting features of the afternoon session was the report on the meeting at Helsingfors, Finland, by Marietta Barnaby, Gardner, who was a delegate to the meeting. "The Twenty-fifth Anniversary of the *American Journal of Nursing*," was the subject of a talk by Sally Johnson. The remainder of the meeting was devoted to business and a paper by Dr. Austen Fox Riggs, Stockbridge, on "Nursing and Nervousness."

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RESTORING THE SICK TO HEALTH

AND

KEEPING WELL PEOPLE WELL

This double function—*keeping well people well and restoring the sick to health*—is one of the reasons why the hospital idea has been so universally accepted by the American people.

Restoring the sick to health, while originally the only function of the hospital, is more and more being supplemented by the service of *keeping well people well,* and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill balanced metabolism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—*acidosis.* This excess acid is frequently observed for the first time when the patient enters the hospital or dispensary for diagnosis. It is the beneficient service of the hospital staff to go beneath the surface of things and find out the underlying causes.

Whatever may be the remote cause of hyperacidity, the simple corrective measures here discussed should be considered by those responsible for the diagnosis, treatment and care of patients in hospitals and similar institutions. Also a note of warning may well be sounded to those who are well so that they may conserve health.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE—The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

ESSENTIALS IN OPERATING THE HOSPITAL LAUNDRY

By E. G. Giles, Head Laundryman,
Alameda County Hospital, San Leandro, Calif.

EQUIPMENT and arrangement of a laundry plant are important, but proper management must be had to attain efficiency. A standard must be established for thorough routine work throughout the plant on a regular schedule. Further to gain efficiency, it is necessary to establish standards for guidance to be obtained only by keeping accurate and detailed records of each department output, and department time consumed.

Linen and Laundry Costs

In cutting down the cost of a hospital laundry, the start should not be made in the laundry, but in the buying of the linen, and in the hospital itself.

As the laundries in the United States were having considerable trouble in damage to Turkish toweling, the department of chemical engineering of the Laundry Owners' National Association submitted samples to their chemical department at the Mellon Institute. When Turkish towels, which were bought at the retail counter, were submitted it was found that they could be purchased at various prices ranging from fifteen cents to $1.50 each. Examination of all grades indicated that those priced below fifty cents were similar in size only, while those priced from fifty cents to $1.50 seemed to present differences in quality and in cost in that they were more or less decorative in pattern and color.

From this group of articles, five towels were selected as representing the actual visible differences in value. The observations made on these samples are recorded in the table below:

		Thread Count (threads per inch)		Tensile Strength (lbs. per inch)		Size	
No.	Cost	warp	filling	warp	filling	length	width
1.	$0.15	32	40	21	52	32 in.	18 in.
2.	.25	32	30	21	63	42 in.	22 in.
3.	.50	28	36	21	38	46 in.	24 in.
4.	1.00	40	60	61	51	48 in.	26 in.
5.	1.50	28	48	31	22	48 in.	26 in.

A study of this table shows several facts. The first is that samples 1 and 2 are of approximately the same grade, the difference in price being due only to the difference in size. The difference in prices between samples 3, 4 and 5 seems to be accounted for in quality, since they are all about the same size. Comparison of them, one with the other, and with samples 1 and 2, shows sample 4 to be far superior to all the others, both as to the number of threads per inch and the tensile strength. It is also moderately priced.

The physical appearance of sample 4 bears out this data: The warp threads were two-ply and tightly spun, while the warp threads of the other samples were single ply and loosely spun. In addition, the foundation fabric of sample 4 was more closely woven, thereby making it firm without any undesirable stiffness. In fact, sample 4 was in every way finer and softer in appearance than any of the other samples.

One of the greatest trials of a hospital is the sheeting. Too much cannot be said about this one article. Great care must be taken in buying sheets, also in the use of them, as there are few on the market today that are not filled.

I am looking forward with great interest, to the time when hospital superintendents will order the sheets with a red line woven through them. If a red line were woven through the sheets, one each way, I believe the hospital superintendents would find that the sheets would last much longer, as the employees would not find them very attractive for uniforms or other wearing apparel.

One of the big costs of a hospital laundry is the marking of the employees' wearing apparel. This cost should be watched and, with the aid of a marking machine, could be reduced to a minimum. All the employees' laundry should be marked in the laundry, as the owner's mark is generally not in the proper place, and many articles reach the laundry not marked at all. This causes much loss of time in looking for a mark which is either not in the proper place, or not there at all.

The only way to keep a standard of linen for the wards and other floors of a hospital, is to have all the linen marked according to the ward or floor. With this system all the linen will be in circulation and one floor or ward will not have a surplus amount of linen on its shelves, while other wards or floors will be without any.

With this system in effect, the task of determining the amount of linen used by each ward or floor, the length of time it lasts, and if any is lost, will be greatly simplified. Furthermore, if the nurses know their supply is limited, they will be more careful in the use of it, and see that the soiled linen is sent to the laundry promptly.

Precautions in Making Bleaches

Care must be taken in making bleaches, as it is almost impossible to make a bleach which will stand up for any length of time without the appearance of from 1 to 2 per cent free caustic. A bleach having this percentage of excess caustic will, at best, hold but 12 to 13 per cent available chlorine, by weight, in the form of sodium hypochlorite. There should not be an excess of free

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Norwegian Lutheran Deaconesses Hospital and Institute
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Architect:
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Plumber:
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Hudson River State Hospital
Poughkeepsie, New York

Mercy Hospital
Janesville, Wisconsin
Architect:
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Architect:
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caustic or other dissolved salts. These can be detected by using a hydrometer.

Liquid bleach must have a specific gravity of from 1.19 to 1.24 United States Bureau of Standards. The best is from 1.21 to 1.22. When above these points it indicates excess caustic or other dissolved salts. The most commonly found are sodium chloride salts. Good bleach should not contain iron or permanganate, as both are bad for the linen. I believe the best bleach is made from chloride of lime by reacting with soda ash or modified soda.

The three standards for the wash room are water, soap, and bleach. Poor bleach causes hard water, and hard water requires more soap. Therefore, a good bleach is an absolute necessity to obtain the best possible results with the least possible expenditure.

Soap, water, and other materials are not the only waste in the laundry, but oftentimes, steam is also wasted. Leaky outlet valves waste water and, consequently, soap also, as we know the more water used, the more soap required. Since leaky valves are often responsible for poor laundry work, it is well to inspect the valves occasionally.

Work cannot be finished on time when breakdowns occur. It is well to look after the extractor and thus save time and expense. See that the operator loads it properly. Watch the belts and see to it that they are not creeping onto the tight pulley instead of the loose one. To allow this is a waste of time, as it keeps the operator busy trying to keep the belts on the loose pulley. The belts should be in a good pulling condition so that they will take hold at once. A waste of time at the extractor means a waste of time throughout the laundry.

Value of Well-Kept Presses

Clean, well-kept presses do not soil the clothes and do not take wash-overs. Use all the clean covers and padding you need, as they can be washed when necessary. Be careful that the garments do not dry out before going on the press. Finish up one thing at a time. For example, do your lot of shirts, then aprons, and other clothes. Do not forget that a properly oiled, cleaned, and padded press makes the work easier.

Time is sometimes lost at the flat work ironer on account of low steam pressure, or poor extractoring. As this is also a waste of steam see that the steam is turned into the flat work ironer in time to have it in a working condition when employees come to work.

In shaking out the linen, have the sheets and spreads put on poles, and all the small pieces on a table. Have the small pieces shaken out and the sheets put on the poles at the same time. In this way shakers never get behind. See that your shakers do not look around the laundry and try to shake linen at the same time. One or two quick snaps are sufficient to take the wrinkles out of a towel or slip. Also, impress upon the shakers the need of more careful handling of old and worn linen.

The proper operation of a laundry is a science and an art. It is very necessary that the laundry superintendent should know the nature of the goods he handles, in order that they may be handled properly and without undue wear and tear. The present day laundry superintendents are becoming well posted on textiles, and, also, the proper reagents in restoring soiled linens to usefulness, and the proper methods of using these reagents.

If hospitals are going to operate their own laundries, they should, at least, provide themselves with trained and intelligent laundry superintendents to look after their laundry work.

THE PROS AND CONS OF DIFFERENT TYPES OF BOILERS

By JOHN E. DUTCHER, Schmidt, Garden & Martin, Architects, Chicago, Ill.

THE ideal boiler condition would be reached were we to put pure water in the boiler, burn under it fuel that did not contain ashes or soot and did not smoke. Had we such water and such fuel the efficiency of the boiler would not be affected whether its tubes were straight or crooked or contained inaccessible pockets. There would be no scaling on the interior of the boiler and no soot to clog tubes and make surfaces ineffective.

The water in every locality varies and in some localities it varies constantly throughout the year. This makes a varying condition on the inside of the boiler, especially if it is used for high pressure steam. The solids in the water are deposited on the various surfaces filling up inaccessible pockets and reducing the area and effectiveness of the heating surface. The quality of the water, therefore, is one of the determining factors in the way the boiler should be built.

To illustrate, the following is an analysis of city water supplying a community in the southwest:

PHYSICAL CHARACTERISTICS	Parts per Million	Grains per Gallon
Suspended Matter	10.0	.....
Total Dissolved Solids	437.72	.....
Turbidity	20.0	.....
Color: Faint Yellow.		
Odor: Musty-Distinct.		
CHEMICAL CHARACTERISTICS		
(Expressed in terms of Calcium Carbonate)	Parts per Million	Grains per Gallon
Hardness	310.0	.....
Alkalinity (P)	0.0	.....
Alkalinity (M)	300.0	.....
Mineral Acidity	.....	.....
(Note: P indicates reaction to Phenolpthalein and M indicates reaction to Methyl Orange.)		
CHEMICAL COMPOSITION		
INCRUSTING SOLIDS	Parts per Million	Grains per Gallon
Calcium Carbonate	260.0	.....
Calcium Sulphate	.....	.....
Calcium Chloride	31.0	.....
Magnesium Carbonate	15.0	.....
Magnesium Sulphate	.....	.....
Magnesium Chloride	0.72	.....
Iron Oxide	10.0	.....
Aluminum Oxide	30.0	.....
Silica	10.0	.....
Suspended Matter	.....	.....
TOTAL	356.72	.....
Pounds per 1,000 Gallons	4.10	.....
	Parts per Million	Grains per Gallon
NON-INCRUSTING SOLIDS		
Sodium Sulphate	41.0	.....
Sodium Chloride	50.0	.....
Sodium Carbonate	.....	.....
TOTAL	91.0	5.3
DISSOLVED GASES		
Free Carbon Dioxide	30.0	.....
Hydroden Sulphide	.....	.....
TOTAL	.....	1.8

To convert parts per million to grains per gallon, the parts per million are multiplied by 0.06, resulting in 21.4 grain per gallon of encrusting solids per gallon of water, and inasmuch as a 100 H.P. boiler will evaporate 400 gallons of water per hour, 1-6/10 pounds of solids will be deposited by that quantity of water in one hour. However, the whole quantity of water is not renewed every hour, but it can be assumed that one-half is evaporated or otherwise lost; consequently, 9/10 of a pound of encrusting solids would be left in the boiler per hour, or 19-2/10 pounds per day if water of the analysis quoted is used, and water having that proportion of solids is not at all uncommon.

Boilers of the "water tube" type, which have straight tubes, are comparatively easy to clean. They have been in the past, and are today, the most desirable and efficient.

For boilers of a capacity of 150 H.P. and less the horizontal return tubular boiler stands out as the most enduring type. Both types mentioned have long life because the scale from the impure water can be removed easily. There are many instances of boilers of either class that have been in use for thirty or forty years and are still giving service.

When we get away from the type of boilers above mentioned and consider boilers which have bent tubes, such as some water tube boilers, the fire box locomotive type of boiler and portable boilers which are designated as double pass boilers, we have boilers with heating surfaces that are effective but they are not so easily cleaned. The fire box section and the bent tubes produce conditions which make it difficult to remove the scale from the surfaces and out of the pockets, with the result that the fire box boiler and the bent tubes scale up so heavily that the fire burns the iron away and leaks occur in a comparatively short time. On the other hand, in a locality where the water is pure and where the scale that forms can be washed out with a hose, boilers of this type give good service.

It is hard to explain why so many different kinds of boilers are built. The heating surface in one boiler does practically the same work as in another, when computed on a square foot basis.

The portable, two-pass type of boiler is more liable to smoke and generally requires a higher stack to produce equal results.

Fuel Influences Choice of Boiler

The setting and the fuel is another problem that varies with the shape of the boiler and the type of fuel. It is a serious problem to keep the exterior surfaces clean where exposed to hot gases, especially when these hot gases carry ashes and soot-forming material. After the boiler is started up it is only a matter of time until soot and ashes accumulate to such an extent in various places that they prevent the boiler doing any work at all. So the boiler that can be kept free of this trouble is the most desirable.

Boiler settings that would work satisfactorily on hard coal or gas would be failures on soft coal, and we have before us as big a problem in the design and arrangement of the setting, to secure proper combustion, as we have in properly designing the interior. Here again the straight tube, water type boiler and the horizontal return tubular boiler present advantages and have a tendency to outlive the other types.

Low pressure boilers may be of cast-iron or steel construction, and where used in connection with a heating system in which the condensation is returned to the boiler, scale formation is eliminated, and the shape of the boiler is immaterial, provided it has sufficient heating surface, and proper exterior arrangement of fire passage ways. The problem that arises with this type of boiler is to keep the exterior surfaces clean, as the efficiency of the boiler depends upon how clean these surfaces can be kept.

Cast Iron Boiler Gives Long Service

In practice it would be safe to say that the efficiency of the low pressure boiler is reduced 25 per cent by dirty surfaces. In addition to this there are likely to be other losses in the brick-set boiler because of surplus air being drawn into the setting through cracks in brick

work. The portable type of boiler has a tendency to have a smaller loss. The life of a steel boiler, used for heating purposes, is generally less than that of a high pressure boiler because of ashes and moisture coming in contact with the lower portion of the fire box section, especially during summer weather when the boiler is not in use. Cast-iron boilers have large passageways through them and the accumulation of soot and ashes on these surfaces reduces their efficiency. In addition they are more or less subject to the breaking of sections. Generally this fault is caused by improper handling. The cast-iron boiler is not suitable for anything but low pressure work, and should be used only where the condensed steam is returned to the boiler. The life of the cast-iron boiler, if properly maintained, is longer than that of the steel boiler.

Low Pressure Steam Heating

In general, a low pressure steam heating system which automatically returns condensation to the boiler is the one used in the majority of small installations.

The steam pressure is raised in the boiler and this is conveyed through the pipes to the radiators at sufficient pressure to expel the air through vent valves, and the piping is so arranged that water will flow by gravity back into the boiler.

In the vacuum system of heating which is used for larger installations, the air is withdrawn from the system by the use of a pump which eliminates the use of air valves on the radiators. The results accomplished are practically the same but the handling of the air is different. In one case it is expelled and in the other it is drawn out.

The elimination of air valves and their trouble makes a cleaner system and there is no spoiling of walls or ruining of floors because of water being expelled through the air valves.

Buildings are not designed to suit a heating system and for this reason every heating system must be designed to suit the building. There are almost as many different heating systems as there are buildings and it is a mistake to say that one heating system is better than another.

Principal Factors of a Good System

The system that easily heats the building is one which has ample boiler capacity, radiation more than sufficient to take care of the requirements for the respective exposure and other conditions, and pipes of sufficient size to convey the steam from the boiler to the radiators. If any one of these principal items is too small the result is a poor heating system.

In the case of heating by water the boiler conditions are the same as previously mentioned; the size of radiators and the size of pipes is the main thing to be considered. To get balanced distribution of sufficient steam to heat all radiators at the same time is a real problem in design, as is also the sizing of pipes. There are more poorly designed water systems than steam systems. The really perfect water system is hard to obtain.

The height and tightness of the chimney is another important feature of a heating system. All brick work is more or less porous and many heating plants do not operate properly because the chimney is too low or allows such an excessive amount of cold air to be pulled through its brick walls that the boiler cannot do its work and an insufficient quantity of air is supplied to the fuel on the grates. Thus the boiler cannot function as its designer intended that it should.

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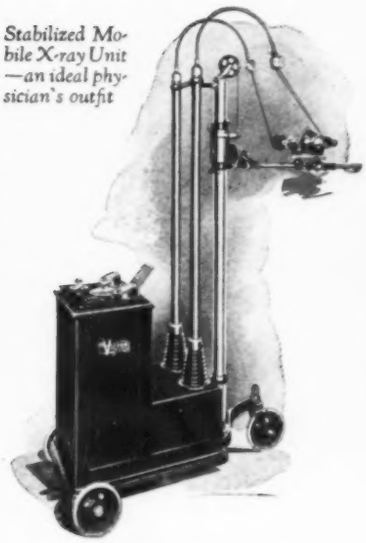

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A Point of View

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—James Harvey Robinson in "The Humanizing of Knowledge"

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(17-239)

SHOULD THE SMALL HOSPITAL INSTALL A WATER SOFTENING SYSTEM?

Superintendents of small hospitals are wont to say: "No doubt such-and-such a device is a good thing for the larger institutions, but this is a small hospital and we cannot afford it. But mechanical short-cuts and labor saving devices are just as economical for the small as for the large institutions. The great majority of them are adaptable to hospitals of almost any size and where adapted, can effect economies sufficient to justify their cost and upkeep.

Excellent proof of this is found in a fifty bed institution in Illinois. Among other outstanding pieces of equipment found at this hospital there is a complete water softening system that has been installed and operated with gratifying results. Practically no department throughout the institution has failed to recognize the value of the system. Every department head speaks highly of the scheme and the power plant engineer says that it is the most profitable piece of equipment in the hospital.

In several of the departments noteworthy economies have been effected. In the laundry, for instance, the use of softened water has cut the soap consumption from one barrel to one-quarter barrel per month. So small are the soap requirements of the laundry at the present time that it would not be profitable for the hospital to try to make its own soap from the waste fats and greases from the kitchen. That this laundry is turning out a high quality of work is evidenced by the fact that the canvas cover on the mangle is not changed nearly so frequently as is customary in laundries using hard water. Furthermore, the soft water materially lengthens the life of the textiles, for according to the statement of the superintendent, the life of the linen has been increased at least fifty per cent through the use of softened water.

Reduction in Soap Powder

Another instance of saving is in the kitchen where the soap powder requirements have been reduced nearly eighty per cent. This direct economy, coupled with the indirect saving of labor in washing dishes, cleansing greasy pans, and in shining glassware, totals an appreciable sum when calculated on a yearly basis.

Thorough softening of the water has eliminated all scale from the boiler tubes in the power plant. This elimination saves the labor of cleaning twice each month that would be necessary if hard water was used. Since cleaning boiler tubes is a day's job for one fireman, the elimination of this task saves at least $150 a year in labor costs.

Of even greater value, however, is the saving in fuel. Scale formation is a most effective insulator and its elimination naturally affords increased conductivity of heat. Scale one-quarter inch in thickness in boiler tubes will increase fuel consumption and decrease the boiler efficiency ten per cent. And ten per cent of the annual fuel consumption at this hospital, totals well over seventy tons, or about $300.

Boiler repairs are obviously more frequent when the tubes are subject to periodic cleaning than when such cleaning is unnecessary. The absence of scale also frees the tubes from the dangers of serious ruptures. The elimination of lime, magnesium and other corrosive elements from the water naturally minimizes pitting or corrosion in the plumbing, coils, sterilizers, and all other material coming into constant contact with the water. Even though the monetary value of such savings is not

easily calculated, they do have a recognized value, as proved by the experiences of power plant engineers who use hard water.

The water treatment system employed in this hospital is one that requires very little attention and a minimum of expense for its maintenance. Its capacity is 11,000 gallons and the only material needed for its continued function is 125 pounds of salt, four pounds of alum and 1,500 gallons of back-wash water, every forty-eight hours. The system is simple in construction and since the installation, eighteen months ago, no repairs have been made.

A SOOT BLOWER THAT SAVES $300 ANNUALLY

An interesting bit of evidence of the value of mechanical overhand means is found in the power plant of a fifty-bed hospital in Illinois.

Instead of freeing the boiler tubes of soot by means of the universally employed hand lance, a mechanical soot blower has been installed for that purpose. It is a simple device for injecting high pressure, live steam into each of the tubes, thus blowing all accumulated soot out the rear end of the tubes where it can be scraped into the ash pit. The whole operation of blowing the boiler tubes in this way requires no more than two minutes of the fireman's time. For this reason the device is used two or three times a day, with the result that there is little or no soot in the tubes to impede the passage of air and heat.

With the old hand lance, the work of cleaning the boiler tubes is disagreeable for many reasons. It is usually necessary to deaden the fire—a thing which in itself increases fuel consumption. The opening of the upper doors allows cold air to circulate throughout the boiler, while the passage of the lance draws much of the soot into the boiler room. Since the work of cleaning the tubes with the hand lance requires at least an hour and a half of the fireman's time, it is a job usually put off until late afternoon. Under this method the tubes are cleaned only once a day.

Disregarding the increase in fuel consumption attendant to cooling the water and deadening the fire, the actual labor cost of cleaning tubes with a lance is in excess of one dollar. This means an investment of over $350 a year, merely to keep the tubes clean.

In comparison, the mechanical soot blower does the work far more efficiently and at practically no cost. So inexpensive is the device that after the deduction of the usual interest on investment, depreciation and repair charges there still appears a net saving in labor costs of over three hundred dollars a year.

NATIONAL DIRECTORY OF SPECIFICATIONS

The Bureau of Standards in cooperation with the Bureau of Foreign and Domestic Trade of the U. S. Department of Commerce has recently issued a national directory of commodity specifications. The directory contains information regarding the best known specifications for more than six thousand commodities. It tells what specifications are in general use and also by whom they were prepared and where copies can be obtained. In it are indexed for ready reference about 27,000 specifications prepared by the Federal Specifications Board and the separate departments of the government, state and city purchasing agents, public utilities, technical societies, and trade associations.

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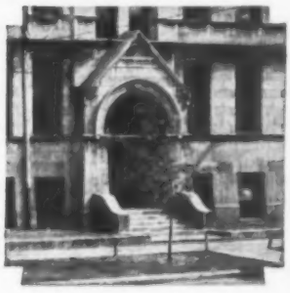

A Quarter Century of Service

Since the founding of DePaul University, in 1898, its scope and influence have grown far beyond the neighborhood limits of those days. With several large buildings on the near north side of Chicago and a splendid School of Commerce in the Loop, it now serves a student body of more than four thousand. Its departments include Schools of Law, Commerce, Music, Shorthand and Liberal Arts as well as two accredited high schools, the Loop High School (evening) and DePaul Academy.

That DePaul University has continuously bought its foods from John Sexton & Company during the past twenty-five years, is a high tribute to Sexton Service and Sexton Foods. During that time this company, too, has grown. It is now a national institution, rendering a specialized service to hotels, restaurants and other institutions throughout the country. Sexton Service means quality foods packed in economical containers for use by those who serve many people each day. Our supply of this season's pack is complete. Now is the ideal time to provide your winter's requirements.

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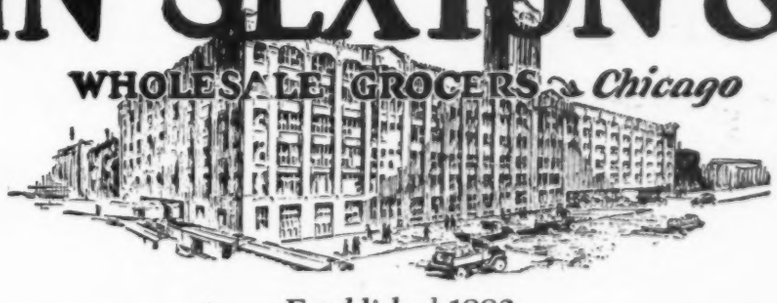

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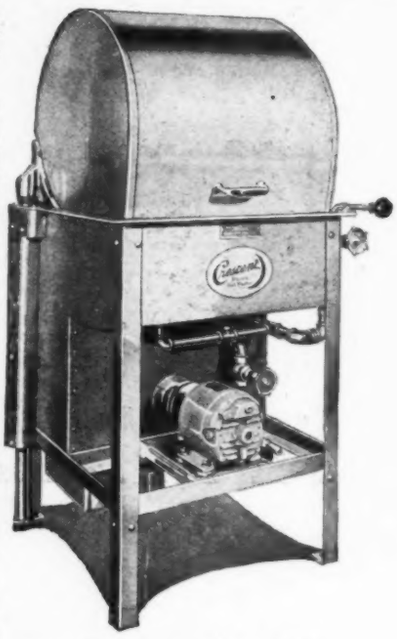
NEW DISHWASHER FOR SMALL INSTITUTIONS

A new electric dishwasher has been designed for small hospitals, diet kitchens and small kitchens of every kind serving not more than one hundred persons at one sitting. It is conceded to be able to clean 1,500 dishes an hour, washes every dish twenty times yet cleans a rackful in twenty seconds.



The machine is equipped with both a steam injector and gas burners so that either gas or steam can be used to keep the water at the right temperature. It has a ball bearing dome shaped hood, the dome being especially designed to retain the steam when the hood is raised. In order that the hood can not be raised while the machine is washing, or that the wash cannot be turned on while the hood is raised the machine is controlled by a safety lock.

HOW REGULATING TAPE SIZES SAVES TIME

One dispensary has an unusual method of eliminating the necessity for doctors or nurses continually tearing adhesive tape.

As is the case with the majority of hospital dispensaries patients' visits are on the appointment system basis. This naturally results in a very heavy demand for personal service in a short time.

The tape board used at this dispensary is a thin, enameled wooden board, the dimensions of which are twenty-four by twenty-four. It is hung on the wall, directly over the supply cabinet, by means of two screw eyes and hooks. On this board are tipped a great many pieces of adhesive tape. These pieces vary in size, some being long and narrow, some short, others wide, with still others square or round.

Having these pieces of adhesive tape within easy reach of the attending nurse or doctor is a source of marked economy in time, since their provision makes it unnecessary for the nurse or doctor to tear the required tape from a roll. Experience has indicated the number of strips of tape required for one day, so that no more tape is torn than will actually be required. This prevents the waste of tape resulting from having the strips hang on the tape board for longer than twenty-four hours.

NUMBERING THE PATIENT'S TRAY

In hospitals where diet kitchens are maintained on each floor, and more particularly in the smaller institutions, each patient can be assured of receiving the same tray at every meal by merely affixing a small square of adhesive tape to the edge of the tray, on which has been written, with ink, the number of the patient's room.

PROVIDING JAR COVERS WITH HANDLES

Every clinic has a number of jars for holding probes, cotton swabs, prepared pieces of gauze, and other articles in common use. If tight fitting glass covers are used for these jars, there is considerable time consumed in replacing the cover after part of the contents has been removed. Indeed, the nurse or attending physician will not take time to replace a tight fitting cover, with the result that the jar is either uncovered or but partially covered while in use. The contents of the jar are thus exposed to contamination of various sorts.

The possibility of these jars being left open or only partially closed, can be eliminated by the use of a flat glass cover that is much too large for the opening of the jar. Such a cover merely rests over the opening and can be lifted or replaced with much greater ease and speed than a tight fitting cover.

However, these flat glass covers are seldom provided with handles, so that unless a handle is made the cover is inconvenient and nothing is gained by the substitution. Handles for the glass tops can very easily be made by sticking a strip of adhesive tape, two or three inches wide, to the top of the glass in such a manner as to leave, in the center of the strip, an upright tab about two inches high. This perpendicular tab, which is merely the center of the tape folded against itself, affords an effective handle for the flat glass cover.

A BED BUMPER THAT PROTECTS WALLS

A new type of bed bumper has been designed to overcome the disfiguration to walls and baseboards occasioned by the beds being bumped against them continually. This has constituted one of the outstanding difficulties in hospital maintenance.

The bumpers consist of a specially compounded rubber disc that fits over the bed leg and protrudes from the post about an inch. They are furnished in two colors, gray and buff, which do not smear or smudge when they touch the wall and are so constructed that the wearing surface may be constantly changed. While they fit snugly to the bed post, the round ones slip a bit with each jar so that the wear is distributed along the entire circumference. For those beds having square posts, the bumpers may be revolved as occasion demands.

REARRANGEMENT OF KITCHEN BRINGS SAVING

The payroll of a Long Island hospital has been reduced about one hundred and fifty dollars a month by a slight rearrangement of the kitchen and dining rooms. The cost of the change totaled about one thousand dollars and the net saving the first year came to about three hundred dollars.

The kitchen was changed so that two dining rooms could be built on both sides of it. One of these was for the doctors, one for the nurses, another for general employees and the fourth for kitchen employees.

All service comes from one kitchen. The doctors are given personal service by waitresses while those in other rooms serve themselves cafeteria style by choosing their foods as they pass the steam table. There is no confusion in service, as each of these groups to be served has a definite time for dining.

TEXTILE MILL EXTRACTOR USED BY LAUNDRY

In the dying or carbonizing rooms of every textile mill, large centrifugal extractors are employed to whirl the excess water or dye from the wet fabrics. These extractors are identical in principle with their miniature prototypes used in almost every hospital laundry.

In preparation for the increased demand for laundry service, brought on by the new addition now being completed, and also to increase the present capacity of the laundry, Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, recently installed one of the large, textile mill extractors.

The extractor is of the "under-driven" type, the motor being directly connected to the shaft of the basket from below. This arrangement frees the ceiling from overhead shafting, pulleys, belts, etc., (which frequently drip oil or grease) and provides the extractor with an open top. The open top feature has the decided advantage of permitting access from all sides, thus increasing speed in loading.

Extractors, because of their high speed, have always been more or less dangerous for workmen. That the larger and heavier machine might be made "fool-proof," Mr. Beecher W. Jones, manager of the laundry, has devised an ingenious contrivance that automatically controls the switch. When the basket is being loaded with the cover open, it is impossible to start the motor, since the control renders the motor inoperable while the cover is up. Once the extractor has been closed, the starting of the motor automatically locks the cover, that cannot be unlocked or opened until the extractor has come to a full stop.

In commenting on the extractor, Mr. Jones said: "This machine will do the work of four of our smaller extractors with a power requirement only slightly in excess of one. We run our loads ten minutes, which time leaves just the proper proportion of moisture in the linens for one pass through the flat work ironer. The accessibility of the machine, brought about by the open top and under-driven mechanism, makes it practicable for many hospital laundries.

"When we purchased the machine the motor shaft housing in the basket extended only half way to the top. We had a brass spindle added to that shaft housing that would reach to the top of the basket, and form a base around which the clothes could be loaded. We believe this additional brass spindle prevents much tangling. Since then the company making the machine has added that feature to the present model."

THE SMALLEST X-RAY TUBE

The smallest Coolidge tube, used in the portable x-ray outfit recently developed, operates at 56,000 volts (maximum) and ten milliamperes. The bulb, one and one-half inches in diameter, is of glass which contains, by weight, 55 per cent of lead. The wall thickness, of ⅛-inch, offers protection equal to that of a $\frac{3}{32}$-inch sheet of lead. The window from which the x-rays emerge is of thin-walled, lead-free lime glass. The tube is but four inches long, and is so small that, complete with its transformer and all other necessary parts, it weighs only twenty pounds and occupies a box measuring 6½ by 10½ by 8¾ inches.

One less employee was needed in the kitchen of an Eastern hospital after the dish racks had been placed on casters. The dried dishes are now placed in these movable racks.

Book Reviews and Current Hospital Literature

DIABETES—ITS TREATMENT BY INSULIN AND DIET

By O. H. PETTY, A.M., M.D., F.A.C.P., Professor of Diseases of Metabolism, University of Pennsylvania and W. H. Stoner, A.M., M.D., F.A.C.P., Associate Professor of Biochemistry, University of Pennsylvania.[1]

The crop of primers for diabetics seems to be as good this year as last. This book is one of the products of this field written primarily for the diabetic patient. It may be distinguished by the number of tables it contains; particularly interesting are those of normal weight for men, women, boys and girls, different from those we have been accustomed to using. Among others, there is a set of tables taken from *How to Live* by Fisher and Fiske, representing the fuel value of foods. These are no doubt of value to the patrons of the life insurance companies for whom they were compiled, but in a book for diabetics it might be unwise to present a table of foods of low fuel value including potatoes, corn, peas, and such fruits as bananas and grapes without qualification.

The renal threshold is discussed more fully than in the majority of these primers and attention is given to salt-free diets in hypertension. The usual chapters in calculation of diets, testing urine, insulin and hygiene are present, together with a number of recipes and illustrations of daily prescriptions.—L. G. G.

PEDIATRIC NURSING

By A. LEVINSON, B.S., M.D., Associate in Pediatrics Northwestern University Medical School, Chicago, Attending Pediatrist, Children's Department, Cook County Hospital, Sarah Morris Hospital and Mt. Sinai Hospital, Chicago.[2]

"*Pediatric Nursing*" by A. Levinson, is more than a textbook for nurses. It carries so much information regarding the child in health and disease organized on the basis of twenty or more years of active work with children during the most significant period in the development of pediatrics as a specialty that it is useful in the hands of all professional persons interested in the care of children. The work embodies instructional courses given to nurses at Michael Reese, Cook County and Mount Sinai hospitals, Chicago, and the methods described are in general those prescribed at the hospitals named.

This textbook has the virtue of being the smallest volume on nursing we have seen, without any sacrifice of content, and it does not commit the common error of mere assertion of principles without ample reason for given conditions. On page 19, for instance, the anatomical basis of certain accepted therapeutic measures is given; on page 20, warning is given of possibilities of medical accident if the high position of the bladder in childhood is not appreciated; and on page 31, is indicated

1. F. A. Davis Co., Philadelphia.
2. Lea & Febiger, Philadelphia, 1925.

the meaning of certain recent reactions in pediatric literature against hard and fast interpretation of height-weight measurements.

In other words, as a pediatrician, the author does not demand full cooperation from the nurse without reciprocity. He is just as safe in his statement of situations in which the physician's prerogative must be unquestioned. Eight articles on the diseases of childhood group these conditions in a scientific and perfectly comprehensible system. Methods of treatment are outlined, tables of drugs are given, dosages and certain fixed procedures for nurses as physicians' aids are given. Final chapters furnish the essential psychological and sociological factors which, in many cases, are so weighty in the management of sick children. The publishers are fortunate in the presentation of a work so fundamentally sound on pediatric nursing in which the scientific authority of the author has not led him to regard the child as a patient, detached or detachable from its place in the family and in the social scheme.—S. P. M.

THE NORMAL DIET

By W. D. SANSUM, M.S., M.D., Director of the Potter Metabolic Clinic, Department of Metabolism, Santa Barbara Cottage Hospital, Santa Barbara, Calif.[1]

This small book of seventy-two pages, including a bibliography, is packed with information for every day use in the dietetic treatment of patients in general. It is a compilation of lectures given by the author on: The caloric requirements of the body; the protein requirements of the body; the bulk requirements of the body; acidosis; the mineral requirements of the body; the water requirements of the body, and the vitamin requirements of the body.

Doctor Sansum speaks of these lectures as "a simple statement of the fundamental principles underlying the selection of a normal diet," and this seems to tell the story very well. Even one who is familiar with these principles will enjoy reading this excellent presentation of them; and doctors, dietitians, nurses and patients will find this a valuable handbook.

GYNECOLOGY FOR NURSES

By M. J. SEIFERT, A.B., M.D., F.A.C.S., Attending Surgeon and Gynecologist, Columbus Hospital, Chicago; Consulting Surgeon, St. Mary of Nazareth Hospital, Chicago.[2]

In the preface the author states "the only legitimate excuse for issuing a new book is the desire to present a new thought, or an old subject in a new and practical form." A careful study of this book shows that these self-imposed requirements have been met, for several new ideas are incorporated, and the arrangement of the subject matter is such that the sequence of events in the development of diseased conditions and the treatment of the same are made strikingly clear. The well planned illustrations help in no small measure.

Twenty-nine pages are devoted to what is listed as "medical terminology," really an improved form of glossary which includes the suffixes, word roots and prefixes of the scientific terms that appear in the body of the text. The arrangement of this portion is unusually good for the "big words" used in medicine frequently prove stumbling blocks to beginning students, particularly now when a knowledge of Latin and Greek are not considered an essential part of secondary education.

1. The C. V. Mosby Co., St. Louis.
2. D. Appleton and Company, Publishers, New York and London.

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PRACTICAL INDEX TO ELECTROPHYSIOTHERAPY

By JOSEPH E. G. WADDINGTON, M.D., C.M., Detroit, Mich.[1]

In his "Practical Index to Electrophysiotherapy" Joseph Waddington has confined his labors principally to the physics and techniques of the low and high tension currents and prepared a volume for the neophyte in electrophysiotherapy offering only such theory as shall suffice to bind facts into intelligible conception and application. In addition to the foregoing, a short chapter relative to the less common static currents has been included as well as others dealing with quartz mercury ray therapy and the product of high-frequency currents-ozone. Apart from the theory of this method of treatment there has been added an index of diseases and selective techniques, the types of which should give the novice an adequate key to treatment of diseases and symptoms that have been omited. A cross index of the chapter contents aids the reader in readily securing the wanted information.—R. P.

BOOKS RECEIVED

BONE SARCOMA, an Interpretation of the Nomenclature Used by the Committee on the Registry of Bone Sarcoma of the American College of Surgeons. By E. A. Codman, M.D., registrar, Boston, Mass. With twenty-four illustrations. Paul B. Hoeber, Inc., New York, 1925. Price $2.

METHODS IN SURGERY. By Glover H. Copher, M.D., Instructor in Surgery, Washington University School of Medicine; Clinical Assistant to Barnes Hospital; Surgeon to Out-Patients, Washington University Dispensary; Visiting Surgeon, St. Louis City Hospital. C. V. Mosby Company, St. Louis, 1925. Price $3.

FEEDING AND THE NUTRITIONAL DISORDERS IN INFANCY AND CHILDHOOD. By Julius H. Hess, M.D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Chief of Pediatrics Staff, Cook County Hospital; Attending Pediatrician to Michael Reese and Englewood Hospitals; Consulting Pediatrician, Municipal Contagious Hospital, Chicago; Member of Advisory Board, Children's Bureau, Department of Labor, Washington, D. C. Illustrated with forty-two engravings in the text and one full-page colored plate. Fourth Revised and enlarged edition. F. A. Davis Company, 1925. Price $4.50.

MOTHER'S MANUAL, the Coming and Care of the Baby. By Dorothy Bocker, A.M., M.D., Director of Physical Education, Columbia University; Physical Director for Women at Battle Creek Sanitarium and Ohio State University; Medical Director at Georgia State College for Women; Director, Division of Child Hygiene, Georgia State Board of Health; A. A. Surgeon, U. S. Public Health Service. Brentano's, Inc., New York, 1925. Price $2.

PERSONAL HYGIENE APPLIED. By Jesse Feiring M.D., Professor of Physical Education, Teachers' College, Columbia University, New York. Second edition revised. W. B. Saunders Company, Philadelphia, 1925. $2 net.

ON THE BREAST. By Duncan C. L. Fitzwilliams, C.M.G., M.D., Surgeon in charge of out-patients, and lecturer on operative surgery to St. Mary's Hospital; Surgeon to Paddington Green Children's Hospital and to Mt. Vernon Hospital for Tuberculous, London. C. V. Mosby Company, St. Louis, 1925. Price $10.

1. Published by the author, Detroit, Mich., 1925.